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ABSTRACT

This report of selected sessions from the national conference on "Parents, Children and Continuity" in May 1977 deals with topics of immediate concern to Home Start (home-based) Programs and Child and Family Resource Programs. It is based on notes taken at conference sessions and consists of brief summaries of topics discussed. The conference itself focused on: (1) the most recent research findings pertaining to child development and family centered child development programs, and (2) program and research activities which emphasize continuity into the early school years. Topics highlighted in this report include assessing family needs, implementing home-based programs, individualizing services, parents as educators, bilingual-bicultural programs, single parents, teenage parents, handicapped children in home-based programs, and unique characteristics of urban and rural home-based programs. (CM)

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REPORT OF SELECTED SESSIONS FROM THE "PARENTS, CHILDREN AND CONTINUITY" CONFERENCE
EL PASO, TEXAS
May 23-25, 1977

Prepared by
Sherry Kapfer
Dingle Associates, Inc.
525 School Street, S.W., Suite 301
Washington, D.C. 20024
(202) 554-5532

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P.O. Box 1182
Washington, D.C. 20013
Dr. Ann O'Keefe, Project Officer
(202) 755-7700

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FOREWORD

In May 1977, the Office of Child Development (which was renamed the Administration for Children, Youth and Families in July 1977) held a national conference on "Parents, Children and Continuity." The three major goals of the conference were: (1) to share the most recent developments in the state-of-the-art on parent and family-centered child development programs (including programs serving children under age 3); (2) to highlight recent research findings and ongoing research pertaining to child development programs; and, (3) to share data and program information on major program and research activities which emphasize continuity into the early school years.

In addition to several general sessions, there were 52 concurrent sessions featuring speakers, panels, films, and discussions covering a wide range of specific topics related to the major conference goals.

Because some of the concurrent sessions dealt with issues, concerns, and information of particular relevance and importance to Home Start (home-based) programs and Child and Family Resource Programs, Dingle Associates, Inc., (the firm which provides technical assistance to the Child and Family Resource Program) was asked to prepare a report on selected sessions.

This report, although by no means comprehensive, does include summaries or highlights of 24 different sessions which dealt with topics of immediate concern to Home Start and CFRP---topics such as assessing family needs, teenage parents, handicapped children in home-based programs, problems in implementing home-based programs, individualizing services, and parents as educators.

The Fall 1977 Special Issue of the Head Start Newsletter (which is available through Head Start grantees, most public libraries, or by requesting a copy from: Marie Byrd, Publications Distribution Unit, 330 C Street, S.W., Switzer Building, Room G-311, Washington, D.C. 20201) provides a brief summary of the overall conference, including general sessions as well as a number of concurrent sessions.

This report was written by Sherry Kapfer, of Dingle Associates, Inc., based on hundreds of pages of notes taken by her, Marca Piehata, Marcy Dingle, Sally Schwyn, Clara Noble, Vicki Dean, Norma Slover, Ruth Larson, Lyla Moran, Joan Burns, and myself.

To the note-takers go our thanks for their above-and-beyond-the-call-of-duty help, and to Ms. Kapfer our thanks and admiration for her skill in weaving all the sources together to make this resource---which we hope will be useful not only to those in home-based and Child and Family Resource Programs, but also to others involved in parent-focused and family service programs.

Ruth Ann O'Keefe

Ruth Ann O'Keefe, Ed.D.
Director, Home Start and
Child and Family Resource
Program

TABLE OF CONTENTS

Page

O'Keefe Leads Discussion on Home Start:
Past, Present, and Future.......................... 1

Panelists Highlight Concerns in Planning
and Implementing Home-Based Programs............... 6

Panel Calls Emphasis on Serving Parents
'Crucial' in Home-Based Programs...................11

Unique Characteristics of Urban and Rural
Home-Based Programs Are Delineated.................15

Presenters Demonstrate How Home Visits
Become More Complex As Year Progresses.............18

The Center-Based/Home-Based Combination:
A Match, Not A Miss!...............................20

Home Start Evaluation Findings Are Examined
From User's View...................................23

Importance of Home-School Partnership Emphasized........26

Aronson Leads Group Discussion on Home-Based
Health Component...................................28

Working With Handicapped Children in Home-Based
Programs...33

Conferees Hear Suggestions on How to Make
EPSDT Work...37

Presenters Provide Highlights of Bilingual-
Bicultural Programs................................40

Johnson Leads Discussion on Ways of Increasing
and Improving Parent Involvement...................42

Importance of Parent Education is Emphasized...........44

Lapides Focuses on "T.A." As Framework for
Helping Parents to Help Children...................47

Page

Wichita Parents and Staff Enthusiastic About 'Exploring Parenting' Curriculum....................51

Panelists Present Potpourri of Programs for Parents and Their Babies and Toddlers..............54

Diane Black Relates Experiences in Working With Teenage Parents..................................58

Presenters Question 'Myth' of Independence, Highlight Special Needs of Adolescent Parents......59

Stevenson Tells Participants Ways to Help Single Parents and Their Children..................65

Hilliard and Ramirez Highlight Issues in Individualizing Programs for Parents and Children..68

Conferees Discuss Issues in Integrating Demonstration Programs Into Ongoing Systems........70

Family Action Plan Seen As Core of CFRP.................73

ITC Staff Describe Developmental Assessment.............76

List of Presenters Mentioned in This Report............79

O'KEEFE LEADS DISCUSSION ON HOME START: PAST, PRESENT, AND FUTURE

In a concurrent session entitled Home Start: Past, Present, and Future, Dr. Ann O'Keefe, Director, Home Start Training Centers and the Child and Family Resource Program, Administration for Children, Youth and Families (formerly Office of Child Development), Office of Human Development Services, Department of Health, Education, and Welfare, Washington, D.C., provided an overview of the Home Start demonstration program and current home-based program efforts.

Dr. O'Keefe noted that the Home Start concept has been a part of Head Start since 1971, when a survey was conducted showing that there were approximately 90 home-based early childhood programs operating across the country. Although some of these were research programs which received considerable public attention, Dr. O'Keefe commented that a number of others also were in operation at that time, many funded only on a "shoestring budget."

"The roots of Home Start reach not only into the education field, but also into public health nursing, agricultural extension services, social work, and other areas which have involved taking various services into people's homes," she said.

"We looked very carefully at previous evaluations to learn from their experience," she said, "and the evaluation contractors (High/Scope Educational Research Foundation, Ypsilanti, Michigan and Abt Associates, Inc., Cambridge, Massachusetts) developed or selected a set of 11 measures on health, nutrition, education, knowledge of community resources, etc."

The evaluation design involved three groups, according to Dr. O'Keefe: Home Start children, Head Start center-based children, and a randomly assigned control group. Parents were interviewed and children were tested at the 7th, 12th, and 20th month of participation in the program.

With regard to results, Dr. O'Keefe said that in general, evaluators found that Home Start children made significantly greater gains than those made by the control group, and that the gains made by Home Start and Head Start center-based children were quite comparable.

Dr. O'Keefe told participants that in 1971 Dr. Edward Zigler, then Director of the Office of Child Development and currently Sterling Professor of Psychology, Yale University, New Haven, Connecticut, decided that there should be a Home Start demonstration program within Head Start. Several factors influenced this decision, including the need to see if such a program could be done with a large number of families (since most existing programs served only a few families per program), the need to see if such a program would work in a wide variety of locales (since most existing programs were in predominantly rural areas), and the need to test the feasibility and benefits of a comprehensive, broad services program (since most existing programs provided only one service, such as education).

"Thus, in 1972 the Home Start demonstration program was launched in 16 very varied sites," Dr. O'Keefe said, "with each program serving approximately 80 families."

She emphasized that an extensive evaluation of the program was performed to document the kinds of services delivered, the kinds and numbers of staff needed to carry out the program, the effects the program had on children and their families, etc.

She pinpointed the nutrition component as one which the evaluation showed as needing improvement. She also commented that at one point in the Home Start program fewer children had received their full range of immunizations than in Head Start. Since immunization was part of the overall health education process in Home Start, with parents routinely going with their children to clinics rather than having children immunized in a group or center-based setting, sometimes there were delays in Home Start with regard to immunizing all the children.

Dr. O'Keefe mentioned that in general costs were found to be comparable for operating home-based and center-based programs. She told participants that the evaluators' Final Report is available at no cost by writing to her, c/o Home Start, Administration for Children, Youth and Families, Office of Human Development Services, Department of Health, Education, and Welfare, P.O. Box 1182, Washington, D.C. 20013.

Noting that Home Start ended as a demonstration program and entered its major dissemination phase in June 1975, Dr. O'Keefe said that there are now over 300 home-based programs within Head Start. Although there are a variety of local differences in program operation, she said that all programs selecting the home-based option use the family as the primary system for delivering services. She commented that these 300 or so programs represent roughly one-quarter of the total number of Head Start grantees and that they involve over 12,000 Head Start children. Dr. O'Keefe also noted that while about 13 percent of the children served overall by Head Start programs are handicapped, about 20 percent of the 12,000 children served in home-based programs are handicapped.

"To support training efforts for programs wishing to implement the home-based option, it was decided to establish six Home Start Training Centers (HSTCs) as a follow-on of the official Home Start demonstration program," Dr. O'Keefe said. "Five of the six HSTCs selected were previously Home Start demonstration program sites and the sixth had a long history of home-based training for the handicapped."

She stated that in their first year of operation, the HSTCs trained a total of 1,298 people, [illegible] percent of whom were from Head Start programs while the other 20 percent came from school systems, churches, community organizations, etc., with a focus on parent education. Priority during the HSTCs' first year was generally given to people already operating home-based programs who requested additional training.

Dr. O'Keefe told participants that each of the six HSTCs provides a number of 1-week training sessions at its own location, as well as training, orientations, and briefings at other locations upon request.

She continued, however, that at least 20 percent of staff time is needed on a continuing basis for staff support and training. Therefore, as important as the HSTC training is, one week of any training must be considered only one part---albeit a vital part---of a total, ongoing training effort. Thus, she said, a directory of training programs is being prepared which can both complement and supplement the HSTCs' effort. The directory, which is being developed by Children (1st) First, Inc. in Washington, D.C., will be available in September 1977 and can be obtained from the Home Start Office.

Following Dr. O'Keefe's remarks, she introduced staff from each of the six HSTCs who gave brief descriptions of their programs.

Ms. Sheri Noble, Director of the Millville, Utah HSTC, told participants that her program, located 80 miles north of Salt Lake City near Logan, Utah, serves DHEW Region VIII (six States) and Region X (four States) as well as the State of Nebraska. She said that Millville staff has done Child Development Associate training in the home-center competency area and that next year staff will also provide training in parent involvement. She noted that staff training is aimed at enhancing the responsibility of parents as teachers of their own children. The Millville staff has developed a comprehensive and detailed curriculum guide for home-based programs, which is available at $7.25 per copy from Ms. Noble, c/o Millville Home Start Training Center, Bear River Community Action Agency, 67 S. Main Street, Millville, Utah 84326.

Ms. Kathy Kress, Co-Director of the Portage/Milwaukee, Wisconsin HSTC, noted that her program is unusual in that its home visitors are able to use the public transportation system to make home visits. She said that during its first year of operation the program held 4-1/2-day training sessions for home visitors and added that this year a 1-1/2-day administrative session on budgeting and other administrative matters has been added. Ms. Kress explained that each participant in a training session receives a case assignment at the beginning of the week and then goes on a home visit on Thursday of that week. She stated that the Portage HSTC, which serves Region V, Iowa, and Indian and Migrant Programs east of the Mississippi, plans next year's training design to be more applicable to programs with variations in center attendance.

Mr. Desmond Tarter, Director, Clinch-Powell HSTC, Harrogate, Tennessee, stated that his program, located in Appalachian mountain country, combines home visits, mobile classroom group sessions, and television into its training. He related that the program serves four county school systems, several early childhood programs, Title XX, Appalachian Regional Commission, OE Bureau of Education for the Handicapped, and other programs. He noted that Clinch-Powell HSTC staff members have designed and given 17 different training sessions, ranging from mini-sessions to 4-1/2-day sessions.

Ms. Bernice Andrews, Training Coordinator, Parkersburg, West Virginia HSTC, told participants that the Parkersburg HSTC serves Regions I, II, and III. Among trends she noted was trainees' requests for more specific "how-to" information rather than overall introduction to the home-based concept. She also mentioned that Parkersburg has participated in cluster training, whereby staff from two or three counties come together and use each other as trainers.

Ms. JoAnn Braddy, Director, Dardanelle, Arkansas (ARVAC) HSTC, commented that her staff's training is totally integrated with other Head Start resources, films, books, etc. She said that trainees participating in ARVAC's program make two home visits during the week-long training session---one early in the week of training and one later. Recently a family day care home network has also been established as part of the trainers' regular home visits. Ms. Braddy said that many college students take the HSTC training (for college credit) and that much of the training focuses on broad communication skills as well as trying to meet individual trainees' needs.

Mr. Steve Evans, Assistant Training Coordinator, and Mr. Jack Peters, Director, Adult-Focus Training Center, HSTC, Reno, Nevada, told participants that their program serves Head Start, school districts, and other programs in Region IX and Indian and Migrant Programs west of the Mississippi. They noted that most sessions are held in Reno and last approximately three to five days, but that some sessions are also offered at local program sites. They said the Reno program uses a participant-oriented approach and has extensive audio-visual resources, videotape, and a simulated home living-room area for role plays. According to Mr. Evans, communications and home visiting skills, adult education concepts, and community and family needs assessments are stressed, as are the ways in which Head Start component areas relate to each other.

Dr. O'Keefe closed the session by noting that all HSTCs also provide actual Home Start services to approximately 30 families each and that these families open their homes to trainees during sessions, thus enabling trainees to see---and participate in---a "real, live home visit" with an experienced home visitor. She also noted that generally trainees pay only their own travel and living expenses (i.e., no training fee), and that training schedules can be obtained directly from each HSTC.

PANELISTS HIGHLIGHT CONCERNS IN PLANNING AND IMPLEMENTING HOME-BASED PROGRAMS

Presenters in a session on Concerns in Planning and Implementing a Home-Based Program provided participants with a variety of information relevant to operating home-based programs.

In a panel discussion chaired by Ms. Dorothy Brown, Community Resources Coordinator, Gering, Nebraska CFRP, the first speaker was Ms. Marcy Dingle, President and Project Manager, Dingle Associates, Inc., Washington, D.C. Ms. Dingle explained that in past and present contracts with the Administration for Children, Youth and Families (formerly Office of Child Development), to provide training and technical assistance to the Home Start and Child and Family Resource Programs (CFRP), her staff had found that there is a tremendous difference between "home visiting" and "visiting a home."

"Ideally, home visiting is a system for delivering educational and developmental services in a home-based setting," she said.

Ms. Dingle told participants that all CFRPs have a home-based component and noted that although CFRP Family Advocates are not home visitors, nonetheless they carry out many responsibilities in the home, e.g., child and family assessments.

Ms. Laverne Williams, Director, Tri-City Head Start, Hughesville, Maryland, and former Children (1st) First, Inc. training consultant to Home Start, stressed the importance of the concept of team planning for home-based programs.

"It is important to get all your information together and do all the necessary groundwork before you start visiting a family," she said. "Use a team concept to involve your staff, especially if you are coordinating your home-based effort with a center-based program, as we do."

Ms. Williams noted that often a central staff meeting should be held first and emphasized that it is important to listen to staff members' concerns such as how staff will be used or how existing positions might be changed if a home-based program were implemented.

She also commented that an initial survey of the area to be served by a home-based program helps pinpoint areas which no existing program serves and identify families in which some adult will be at home with whom home visitors can work

"After all the data are gathered, then the similarities and differences between center-based and home-based programs can be identified, cost estimates for operating both kinds of programs can be made, and this information can be presented to parents. Assuming that the decision is made to operate a home-based program, the staff should be made aware of program goals and their own particular responsibilities through a series of staff meetings and training. Then a publicity campaign can be launched," she said.

Ms. Williams advised participants interested in operating home-based programs to try to get involved in the nearest Home Start Training Center's training sessions, and added that it is also important for someone from the program's administrative staff to attend training.

Next, Mr. David Shearer, Director, Portage/Milwaukee, Wisconsin Home Start Training Center (HSTC), emphasized the importance of developing a structured home visit.

"There is a great need for home visitors to develop a relationship based on trust and understanding and yet to realize that a home visit is not a social call," he said. "The home visitor must be prepared. Parents have a lot to do, so structure is important not only for the home visitor but also for the parent."

Mr. Shearer commented that all home visitors need a plan to follow and should establish, with the families, some goals and objectives based on a needs assessment of each family.

"Informality comes naturally, but must start with a plan," he concluded.

Mr. Jack Peters, Director, Adult-Focus Training Center HSTC, Reno, Nevada, also stressed the importance of needs assessment in home-based programs.

"The home visitor must be aware of each family's needs as that family sees them," he said. "These needs must be recognized so that training can be provided and the program can meet as many needs as possible. The role of staff members must also be made very clear, so that everyone understands his/her responsibilities."

Ms. Florence Seguin, Training Specialist, Children (1st) First, Inc., Washington, D.C., emphasized the necessity for supervision and observation of home visitors.

"The best planning makes no difference unless home visitors implement the activities well," she said. "There is a tremendous danger inherent in home-based programs if people with minimal or no training make home visits and if no one goes in to see how the training program is being implemented in the homes." But she also stressed that regular, constructive, supportive supervision is vital to all home visitors, even those with considerable training and experience.

She also added that almost any home visit will be helpful unless it actually harms the parents, but cautioned participants to remember that programs may "cheat" parents of good developmental techniques if the best possible home-based model is not implemented.

On the subject of the isolation that often is part and parcel of a home visitor's job, Ms. Judy Cooper, Director, Salem, Oregon CFRP, listed the following ways to prevent "staff burnout":

1. Adopt a management philosophy that recognizes the human needs of staff and allows staff to acknowledge feelings of inadequacy or the need for help.
2. Strive for a good supervisor/supervisee relationship and provide staff with easy access to resource people, supervisors, etc.
3. Provide a gathering place for staff to get together on an informal basis at least once a week.
4. Provide training that promotes staff closeness, in areas such as communication skills.
5. Allow staff to spend some time giving and receiving support from each other.
6. Use a system of "democratic management," involving group planning and decision-making.
7. Do not make staff responsible for being in the field with families all of the time.
8. Provide time for staff to have fun together, through pot-luck dinners, staff brunches, etc.

9. "Stroke" staff members; praise them for tasks well done.

Dr. Richard Ruopp, Vice President of Abt Associates, Inc., Cambridge, Massachusetts, embellished these ideas by commenting that a child development program is only as good as the people involved in it. Noting that home visitors are the core of any home-based program and are "unique kinds of personnel not found in any other kind of program," Dr. Ruopp said that one of the factors Abt Associates personnel found to be of utmost importance when they conducted the formative evaluation of the Home Start demonstration program was that home visitors should "be of the people they serve and should speak the language of the families they are serving."

Dr. Ruopp also focused on one area he considered to be a problem in the Home Start demonstration program, namely that of home visitors' salaries.

"In 1974, we found that in the Home Start demonstration program, home visitors' salaries were $80 to $130 per week, or in the $4,100 to $7,100 per year range," he said. "A decent wage, which would pull home visitors out of the predicament of being among the lowest five percent of wage earners, would probably be from $10,000 to $12,000 per year."

However, Dr. Ruopp noted that raising the wages of home visitors would not really solve the problem either, because in many instances that would have the effect of closing down day care centers and increasing the case loads of home visitors.

Dr. Paul Vicinanza, Child Development Specialist, Administration for Children, Youth and Families, Office of Human Development Services, Department of Health, Education, and Welfare, Philadelphia, Pennsylvania, listed three positive contributions that he feels home-based programs have been able to make:

1. Home-based programs have proved to be one of several good ways to provide comprehensive child development and family support services.

2. Home-based programs focus clearly on the goals of Head Start for families and children.

3. Home-based programs provide a "level of believability"---i.e., they focus on parents as the first, most important, and most continuous developers of their own children.

In the question-and-answer period that followed, Dr. Ruopp noted that a reasonable case load for a home visitor to manage is probably between 10 and 12 families, depending on the amount of travel involved, the home visitor's capacity, the difficulty of the family situations involved, etc. He also noted that in the fall of 1977, Abt Associates would be publishing Partners With Parents: The Home Start Experience With Preschoolers and Their Families which would provide a picture for the "lay person" of some of the promises and pitfalls of operating home-based programs.

Regarding the use of male home visitors in the Home Start demonstration program, Dr. Ruopp said one way for this to work was when teams of men and women went into the homes together. He added that here again the problem of low salaries for home visitors surfaces, since most men are the primary wage earners and cannot afford to take a job at a salary as low as the ones paid Home Start home visitors.

In response to a question regarding whether exceptional children could be served as well in a home-based setting as in a center-based setting, Mr. Shearer commented that his home-based program has been serving exceptional children for several years. He cautioned participants to remember that each child has his/her own basic needs and develops at his/her own rate, and encouraged them to draw on all available community resources for support. (See also pages 33-36 on home-based services to children with handicapping conditions.)

On the subject of how much individualization is possible in a home-based program, Ms. Seguin stated that home visitors begin by ascertaining what the actual needs of children and families are. She noted that often there are many commonalities among children and families, but said that home visitors also individualize activities for families as much as possible.

Dr. Vicinanza closed the session by warning participants that often the least effective person to make home visits is a person trained to be in the classroom, unless such a person has been well trained in working with adults as well as children.

PANEL CALLS EMPHASIS ON SERVING PARENTS 'CRUCIAL' IN HOME-BASED PROGRAMS

In a session entitled Making the Home Visit a Family Affair, panelists agreed that a focus on parents is critical to the success of any home-based program.

Opening remarks by Ms. Florence Seguin, Training Specialist, Children (1st) First, Inc., Washington, D.C., emphasized that although some home-based programs have involved transfer of staff from the classroom setting to the home, it is always important to remember that parents are the ones to be served.

Ms. Evelyn Murray, Director of the Perceptual-Psychomotor Program, Bristol Virginia Schools, Bristol, Virginia, said, "Our program's interest is in serving parents and educating them to be the teachers of their own children."

The Bristol program, financed by the school system and the U.S. Office of Education, involves senior citizens in making packets of materials (such as puppets, bean bags, etc.) for home visitors to give parents, Ms. Murray said. She also noted that many community resources are involved. For example, children may go to the YMCA twice a week for classes in swimming and creative movement; the Kiwanis Club assists with funding for children who need special help; and the program relies heavily on the local librarian and book club for assistance.

Ms. Linda Reasoner, Training Coordinator, ARVAC, Inc. Home Start Training Center (HSTC), Dardanelle, Arkansas, cautioned participants to remember that each family is individual and has its own goals, needs, and priorities.

"It is important to help staff to become total-family-oriented, rather than focusing on 3- to 5-year-olds," she said.

Speaking of various ways to involve older siblings in home visits, Ms. Reasoner commented that home visitors must first establish a rapport with parents, and in doing so they can ask questions concerning the family's older children as well as their Head Start-age children. She noted that this also helps with referrals, follow-up, etc., and added that once a family becomes aware of available services, older siblings can participate in visits to doctors and clinics, immunizations, etc.

"ARVAC has a lesson plan used by the mother in the home when the home visitor is not there," she said. "We use a basic lesson plan and individualize activities according to family members' needs and goals. We find that often the older children imitate the way their mother works with the smaller children, just as the mother imitates things she sees the home visitor do in dealing with little children."

Ms. Reasoner suggested that home visitors take into the home materials for older children as well as the younger ones. She also said that ARVAC has successfully involved older children in group and parent meetings, and that in such meetings educational material has been presented for parents to use with older children.

"One of the benefits we noted from the Home Start demonstration project was the rub-off effect on 10- to 12-year-olds," she said. "Older siblings can give support to younger children; don't overlook them," she concluded.

Ms. Seguin added that generally once a few members of the family become involved in a home-based program, other family members get involved, too.

Mr. Mike Morcum, Trainer, Reno Adult Focus Training Center HSTC, Reno, Nevada, spoke next on the subject of actively involving fathers in home visits. He commented that home visitors sometimes encounter (1) fathers who are reluctant or afraid to do educational things for their children, or (2) hostile fathers who are opposed to the "know-it-all" home visitor and who either leave the room when the visitor is present or inhibit the home visitor's interaction with other family members.

Mr. Morcum said that there are various ways to overcome such fear or hostility and stressed the importance of father involvement.

"On our orientation visits to a family at the beginning of the year, when the home visitor explains the purpose of the program, the role of the home visitor, etc., we make a deliberate effort to talk to both parents together, to explain the father's role, and to make him feel a part of the home-based program," he said. "Once we start regular home visits, we also try to make him feel a part of the visits. We find out all we can about his hobbies, activities, and interests; we find out what he knows about his children; we ask what he does with his children and what areas he feels uncomfortable about, etc."

Mr. Morcum explained that after a father is more at ease, he can be involved in activities such as going over lesson plans with the mother, participating in some activities, etc.

He also suggested that if a father is away from home and cannot be a part of the home visit, the mother can be asked to act as a home visitor to the father.

"We encourage mothers to explain to fathers the importance of their involvement. We remind mothers not to threaten fathers or push them into activities, but to emphasize that it is not so much the amount but the quality of time a father spends with his children that is important," he concluded.

Ms. Deborah Cochran, Trainer, Portage/Milwaukee, Wisconsin Home Start Training Center, noted that in her program when activities are planned for any family member, program staff members perform: (1) assessment, (2) planning, (3) implementation, including role modeling by home visitors for parents of how to teach activities planned jointly by the home visitor and the parents, and (4) follow-up.

She mentioned that normally a home visit is divided into several segments: (1) a brief period of prescribed activities aimed at the target child which the home visitor discusses with the mother; (2) a period of group activity which includes everyone who is at home, involves all developmental areas, and is planned in an informal manner; and (3) a period in which the home visitor discusses with the mother some of the family's needs (as expressed during the family's assessment), child development information, and any materials of relevance to family goals.

She also noted that the weekly progress report filled out by home visitors includes activities performed with or involving other family members as well as the target child.

Ms. Charlene Johnson, Home Visitor, Portage/Milwaukee, Wisconsin HSTC, stated that on her home visits she attempts to take into consideration (1) the number of children in the home, so that enough materials are provided for everyone, (2) the ages of the children in the home, so that appropriate materials are provided, (3) developmental levels of the children in the home, and (4) activities with which older family members could help younger ones, so that total family involvement could be attained.

In the question-and-answer period, an audience member asked what happens on the initial home visit. Panelists responded that the home visitor observes and discusses with the parents and everyone in the home what activities have been going on in the home, what the children can already do, what the parents have already taught the children, and how they can do more.

Ms. Seguin emphasized that home visitors are not there to "teach" but rather to assist parents. Ms. Reasoner added that often home visitors assist in improving parents' self-concept when parents are not aware that they are already doing a good job with their children. She stressed that home visitors must be careful not to impose their own values on other people.

UNIQUE CHARACTERISTICS OF URBAN AND RURAL HOME-BASED PROGRAMS ARE DELINEATED

Seven panelists, representing a gamut of experience in working in rural and urban home-based programs, discussed the unique characteristics of both types of programs.

In a session entitled Addressing the Unique Needs of Urban and Rural Home-Based Programs, Ms. Kathy Kress, Co-Director, Portage/Milwaukee, Wisconsin Home Start Training Center (HSTC), began by noting that "few" programs in her area elect to operate the home-based option.

"This decision seems to be based on two primary factors: (1) facilities to operate center-based programs are readily available, and (2) children and families live within walking distance of the center or can be easily transported," she said.

Ms. Kress explained that another consideration in urban areas is the proportionately larger number of working mothers whose children are, of necessity, out of the home for a great portion of the day.

She noted that when urban programs do elect to implement the home-based option, there are a number of factors that make the programs different from a rural home-based program:

1. Home visitors in urban programs often do not need to drive; instead, they can often use public buses or walk to their families' homes. If the home visitor does not drive, however, special attention must be paid to the quantity and ease of transporting materials. This often leads to a greater use of homemade materials as well as emphasis on the use of materials already in the home.

2. Due to the availability of public transportation, families are less dependent on home visitors. Home visitors may still accompany families on visits to community resources, but driving families to such places is not a significant function of home visitors. Occasionally, a home visitor may need to assist a family in learning to use the public transport system.

3. Urban home-based programs are more likely to reflect a larger ethnic mix than rural home-based programs. Often, the home visitor must be bilingual and conversant with resources that serve

particular ethnic groups. As in any home-based program, materials must be culturally appropriate and free from stereotypes. Further, as often as possible home visitors should be of the same ethnic groups as the families they serve.

4. Although home visitors' schedules should be flexible, and home visits arranged at the families' convenience, the home visitors' safety in urban areas after dark must be considered as well.

5. Urban home-based programs are able to draw upon many community resources that may not be available in rural areas. A concise resource directory is extremely useful to both home visitors and families in efficiently locating needed services. In addition, families in an urban area may be concurrently receiving services from several agencies. Home visitors can facilitate coordination of these services and help avoid duplication.

6. Urban home visits are more likely to include neighbors and relatives who "drop in" during the home visit; thus, home visitors must be prepared to include everyone present in the home in their activities.

7. Home visitors in urban programs often have greater access to their offices than do visitors in rural programs. They often report to the office during the week to exchange supplies and discuss concerns with their supervisors.

Ms. Kress concluded by stating that the Portage Project operates both a rural and an urban home-based program, and staff have found them both to be effective delivery systems, regardless of locale.

Mr. Desmon Tarter, Director, Clinch-Powell, Tennessee HSTC, spoke about some of the unique characteristics of rural programs. Speaking first of the geographic distribution of families to be served, he cited the sparsely scattered distribution of families and transportation as two major concerns in rural areas. Several factors he discussed were: the amount of travel time needed between home visits, the number of families a program can serve, rough road conditions, pay for home visitors' mileage, transportation of children to group sessions and adults to Policy Council and other meetings, and transportation to medical and other appointments.

Mr. Tarter pointed out that there is often a lack of social services available in rural areas and that appointments for families are often difficult to obtain.

He also commented that children in rural programs often have exceptional health needs. Specifically, he noted that disease rates are high; hepatitis is increasing in rural areas; and often there are many problems of a public, rather than personal, health nature such as unsafe water supplies and inadequate sewage and solid waste treatment. He said that tuberculosis is still a major health problem in rural areas, as are intestinal parasites.

Some of the techniques Mr. Tarter listed for meeting these needs include using mobile classrooms, mini-vans, and educational television; "putting on our hiking boots"; decentralizing clinics and child care programs so that small units function close to families; training and using "physician extenders," midwifery programs, and nurse practitioners in health care delivery; and training local residents to become staff in child development programs.

Other panelists included Ms. Laverne Williams, Director, Tri-City Head Start; Hughesville, Maryland; Ms. Berdine Maginnis, CDA Specialist, Community Development Institute, Denver, Colorado; Ms. Bernice Andrews, Training Coordinator, Parkersburg Home Start Training Center, Parkersburg, West Virginia; Mr. Lowell Enerson, Director, Oklee Head Start, Oklee, Minnesota; and Ms. Floretta Chisom, Director, Oakland Head Start, Oakland, California. Panelists and conference participants conducted further discussion and a question-and-answer period following these presentations.

PRESENTERS DEMONSTRATE HOW HOME VISITS BECOME MORE COMPLEX AS YEAR PROGRESSES

One session of the conference stressed The Developmental Stages of a Home Visit. Ms. Sheri Noble, Director, Millville, Utah Home Start Training Center (HSTC), and Mr. Steve Evans, Assistant Training Coordinator, Reno, Nevada Adult Focus Training Center HSTC, led the discussion. Other panelists included Ms. Malden Riley, Senior Family Advocate, New Haven, Connecticut Child and Family Resource Program (CFRP); Ms. Lauri Roggman, Home Visitor, Millville, Utah HSTC; Ms. Jo Davis, Home Visitor, Millville, Utah HSTC; and Ms. Carolyn deBolt, Home Visitor, Millville, Utah HSTC.

Panelists emphasized that there are two continuing changes that take place in home visits during the year. One is fairly obvious and is reflected in the changing content of material presented. and the other, more subtle, is evidenced in the changing roles and relationship between the home visitors and the parent.

They noted that as the program year begins, the first visits are concerned primarily with orienting the parent to the program and getting to know and understand the family. Next, it is important to develop a good concept of self within both the parent and child. Then, concept areas may be introduced, such as cognitive development; large and small motor development; language development; hearing and sound discrimination; the five senses; nutrition; etc. The most important element here is that each concept builds upon and incorporates previous learning.

Panelists stressed that it is important to remember that the parent is the focal point of the visit and the child is the medium through which the parent and home visitor work, as well as the one who ultimately benefits.

They explained that at the beginning of the year, the home visitor takes the more active role during the visit and generally does such things as planning the lesson, determining activities to be used, and collecting all required materials. As the year progresses, the home visitor attempts to increase the parent's confidence, knowledge, and desire to be the teacher of his/her child. Parents are gradually encouraged to prepare for and collect materials for subsequent visits so that they ultimately assume the active role during the visits.

Presenters commented that through the year the home visitor's position evolves from trying to motivate and teach the parent how to be the teacher of his/her child to the position of teaching more involved subjects and ideas to the parent once the parent has become effective as a teacher. Thus, at the end of the year the home visitor has a less active and more reinforcing role during the visit; that is, he/she has changed from being primarily a motivator to being primarily a resource person, although neither role is ever completely separated from the other.

Panel members also emphasized the need to build on existing family strengths and recognize expressed family needs through a detailed family needs assessment.

Several role plays were provided of an initial visit, a visit near the middle of the program, and one at the end of the program to stress the developmental nature of home visits.

The question-and-answer period involved discussion of the difficulties and realities of day-to-day home visiting and the differences between HSTC and CFRP home visits.

THE CENTER-BASED/HOME-BASED COMBINATION: A MATCH, NOT A MISS!

Ms. JoAnn Braddy, Head Start/Home-Based Training Director, ARVAC, Inc. Home Start Training Center (HSTC), Dardanelle, Arkansas, began a discussion on The Center-Based/Home-Based Combination: A Match, Not a Miss!

She commented, "Our favorite option is the center-based/home-based mix, with children coming into the center two days a week. We find this encourages the highest rate of parent participation, except for a purely home-based program, and the highest rate of volunteers in the center on the days children are there."

She noted that the local community decides which options will be used and discusses how many days will be allocated to home visits, how much time will be spent in centers, etc. She added that staff who were initially reluctant to use this approach have found that it is the best option for their program.

Next, Ms. Betty McIntosh, Director, Snohomish County Head Start, Everett, Washington, said that geographic conditions in her area led to the use of this option. She said that staff in her three centers work in teams---e.g., the coordinator, teacher, assistants, cook, and home educators operate out of the center as a team. She said she feels that the center-/home-based combination allows for more effective individualization of services and provides people with a clearer, more current grasp of the program with the integration of program components.

Ms. Emily Schwab, Parkersburg, West Virginia HSTC, said that the home-based and center-based programs can be seen as two separate programs, both of which are different and serve different needs.

"And," she said, "it is possible that both of these programs can work side by side in a given community as long as the goals and objectives of each are clearly defined to meet the particular needs of children and families in that community."

Before determining which type of program should be implemented (center-based, home-based, or center-based/home-based mix), she noted that the first step should be to make a community needs assessment. Then, families and staff determine which type of delivery system would best meet these needs. Recruitment and enrollment of families then follow.

Dr. Jim Gage, Principal, Richmond School, Salem, Oregon, commented, "Community assessment means assessment of all the elements of the community. You need good information to make good program decisions. Full information about all the options to be considered should be provided to everyone involved in the decision, including staff and parents."

Dr. Gage listed the following as important points to consider in making a decision regarding home-/center-based programs:

1. To operate an effective home-based program, staff must be "tuned in" to parents. Many teachers who work well with children may not want to work with parents.

2. The competencies and skills needed for home visitors are different from those needed for classroom teachers; thus, a program considering implementing a home-based component should plan ample time for staff retraining.

3. Staff in home-based programs must be flexible, a trait which is "not necessarily inherent in" classroom teachers.

4. Home visitors who are "self-starters" are needed in home-based programs.

5. Staff in home-based programs must be able to work with community members and agencies.

6. Home-based program staff must possess parent education skills and be able to communicate with adults.

Dr. Gage also stressed the importance of looking at the child, too, in terms of his/her needs---e.g., intellectual stimulation, socialization, etc.

The last speaker, Ms. Peggy Mihata, Director, Clackamas County Head Start, Maryl Hurst, Oregon, described her program's center-/home-based combination. She noted that her program uses a "cluster" approach, wherein children attend two half-day classes per week, receive one home visit per week, and attend one cluster meeting per week. She commented that families share well in the cluster meetings, which are held in the parents' homes.

"Strong friendships have developed; we see more active interest in community affairs; and we are getting involved in the public schools now," she said. "Since we discovered that the traditional program we ran before did not let parents become actively involved in the education of their children, we now have adopted the philosophy that parents are the prime educators of their own children."

HOME START EVALUATION FINDINGS ARE EXAMINED FROM USER'S VIEW

A session entitled Home Start Evaluation Findings: A User's View provided answers, based on evaluation data, to questions that might be posed by home-based program practitioners.

Mr. Dennis Deloria, Chief, Evaluation Branch, Research and Evaluation Division, Administration for Children, Youth and Families (formerly Office of Child Development), Washington, D.C., began the discussion by citing general findings of the evaluation on the Home Start demonstration program. He told participants that narrative data for the formative evaluation were gathered on all 16 Home Start demonstration sites but that test data for the summative evaluation were gathered on two urban and four rural sites. He also noted that evaluators compared members of a Home Start group, a Head Start group, and a group of families who did not participate in the program for one year and then entered the program.

"In general, we found that the children in Home Start seemed to do at least as well as the children in Head Start," he said. "Further, when compared with a randomly assigned control group, children in Home Start did better than control group children on the Preschool Inventory, the ability to use language, and task orientation, and had more recent medical and dental care of a preventive, rather than crisis, nature."

He continued, "We also found that parents of children in Home Start allowed their children to help more with tasks around the home, spent more time reading to their children, provided more books and playthings, asked children more questions (rather than telling children things), and were more involved in their children's world, when compared with control children."

He added, however, that although parents of children in Home Start were more involved in community organizations, they didn't use community resources any more than those in the control group.

Mr. Deloria explained that at the end of one year, the control group families were brought into the Home Start program and that they seemed to show the same changes once in the program.

Noting a few differences between Home Start and Head Start, Mr. Deloria said that Home Start mothers seemed to teach reading and writing more than Head Start mothers, while Head Start seemed better able to deliver services in the area of nutrition since Head Start provided meals and there was no comparable delivery system in Home Start.

Dr. Richard Ruopp, Vice President of Abt Associates, Inc., Cambridge, Massachusetts, commented that home-based programs may end up serving different families than Head Start due to the fact that many parents who work full-time cannot participate in a home-based program since the mothers are not at home. Thus a center-based program may also be serving a day care need.

Dr. Ruopp said that evaluators found the "unit cost per child" to be roughly similar for Home Start and Head Start, but that since Home Start had a "ripple effect" due to its impact on other family members, it was probably more cost-effective than Head Start.

In response to a question regarding how home visitors can deliver nutrition services, Dr. Ann O'Keefe, Director, Home Start Training Centers (HSTCs) and the Child and Family Resource Program, Administration for Children, Youth and Families, Office of Human Development Services, Department of Health, Education, and Welfare, Washington, D.C., stated that most home visitors perform nutrition education services. She added that the Clinch-Powell, Tennessee HSTC has published a handbook of "tried and true" nutritional aids for use with families.

One audience member asked about the level of education of home visitors in Home Start. Dr. Ruopp answered that they were mostly paraprofessionals without a specialty in any given field but were people who came from the neighborhood they served. Dr. O'Keefe stated that in some programs, such as Dr. Phyllis Levenstein's Verbal Interaction Project, Freeport, New York, nonparaprofessionals have been used quite successfully; she said one problem with using nonparaprofessionals in Home Start was the low salary paid home visitors. Ms. Kathy Hewett, Consultant, Abt Associates, Inc., added that Home Start programs looked for personal qualities, ability to work well with adults, concern for others, etc., in hiring home visitors.

In response to a question regarding CDA training for home visitors, Dr. O'Keefe said that much interest has been shown in adapting the CDA credential to home visitors and that there are plans for eventually providing CDA training for home visitors. She also noted that the revision of the Head Start Performance Standards will include standards for home-based programs as well as Parent Child Centers.

Concerning the ideal frequency of home visits, Ms. Marritt Nauta, Consultant, Abt Associates, Inc., told participants that the evaluation showed that more frequent contact was most beneficial with families. She noted that in Home Start, in addition to home visits once a week, there were a lot of "pop-in" visits and other contacts with families. Dr. Ruopp added that the week is a "meaningful unit in family life, particularly since weekends can promote crises" and said he advocated home visits at least once a week. However, he also commented that visiting every family twice a week would clearly be using resources that could be used elsewhere and reminded the audience that some families don't want---or need---to be visited that often. Ms. Nauta added that several Home Start programs established "contracts" or agreements with families regarding what both the program and the family would do, when the family would be scheduled to terminate the program, and what options for renewal of the "contract" might be.

On the general subject of, "If you had it to do over again, how would you change what you did in Home Start," Dr. O'Keefe said that the best of adult education techniques should have been incorporated in Home Start from the beginning and noted that it took almost a full year for many program staff to be able to work competently and comfortably with parents as well as children.

Ms. Hewett added that collection of data on families is important and said some people criticized the evaluation because it did not deal sufficiently with the effect Home Start had on families.

Dr. Ruopp suggested that within the first months of a family's entry into a home-based program, a recommendation should be made regarding how long the family should stay in the program. He said that this would provide a framework for expectations, a framework for detailing what happens to their children over a period of time, and a framework for providing training and support to home visitors. He also suggested that several curriculum modules be developed that could be "plucked off" by programs as needed, and that the Home Start evaluation findings be used to help determine pre-service and in-service training.

IMPORTANCE OF HOME-SCHOOL PARTNERSHIP EMPHASIZED

Dr. Walter Hodges, Director, Follow Through, Georgia State University, Atlanta, Georgia, led off a discussion entitled Programs for Parents and Their School-Age Children by emphasizing the need for a strong home-school partnership.

The program Dr. Hodges directs is an 8-year-old effort which includes 600 multicultural families in Georgia, Louisiana, and Kentucky. According to Dr. Hodges, the major goal of the program is to improve children's basic skills and help them to read, write, and cipher by the completion of the primary grades.

Three home instruction models are used in the program. The first involves a teacher, a home visitor, and a teaching assistant and utilizes both home instruction and classroom instruction. The second model uses a home visitor, who does no classroom instruction work. In the third model, the classroom teacher performs some home visiting and the teaching assistant also shares some home visiting responsibilities. Dr. Hodges said the third model has seemed to be the most economical and has elicited the best response from parents.

Curricula include lessons in sensory, perceptual motor, communications, problem-solving, and affective skills. Learning kits, game kits, and newsletters with ideas for learning are used. According to Dr. Hodges, the working relationship between the university and the schools benefits both institutions.

"The link between home and school provides integration and cohesiveness that enhances continuity in education," he said. "This can be accomplished by professionals such as social workers, education personnel, and psychologists. Paraprofessionals provide this service as assistants to teachers and as home visitors."

Dr. Hodges commented that most teachers have become enthusiastic about home visiting and called this a "dramatic change" from their attitudes at the beginning of the program.

Next, Mrs. Shelby Johnson, Director, Parent Education Demonstration Project (PEDP), Atlanta, Georgia, spoke of her work with 38 school systems which have parent-child programs (such as Title I, Title IV, Head Start, and Right to Read) in eight States of Region IV.

According to Mrs. Johnson, the objective of the PEDP is to strengthen these systems in terms of parents' roles in the education and development of their children. The program has involved infants, preschoolers, and school-age children; staff has ranged from 1 to 42; and the number of families served from 20 to 480.

Major ways in which PEDP staff reach parents include workshops, home visits, mobile and stationary classrooms, and a toy/materials lending library.

Both Dr. Hodges and Mrs. Johnson expressed great concern about the need for staff development.

"Staff selection is critical, as is staff development," Mrs. Johnson said. "Teachers and administrators must recognize the importance of parent involvement in the education of their own children and the extension of their own role beyond the classroom."

Mrs. Johnson also stressed the importance of local support for parent involvement and suggested that projects be given publicity and decision-makers be given credit whenever possible.

Dr. Dorothy Rich, Director of the Home-School Institute (HSI), Washington, D.C., stated the goal of her program as being to enhance children's abilities as learners and to build adult competencies as teachers. She noted that the HSI provides a variety of programs and publications for teachers, parents, teenagers, and other community adults.*

She told participants that during the 1974-75 school year, eight first-grade teachers volunteered to participate in an HSI, Washington, D.C., study known as the Home Educational Learning Program, designed to research the effects of sending a series of home learning activities to a group of families. According to Dr. Rich, the data indicated that the parents did in fact work with their children on the activities, and these children (the treatment groups) achieved significantly higher growth in reading.

"The past decade of research has clearly supported the idea that the home plays a vital part in the learning process," Dr. Rich said.

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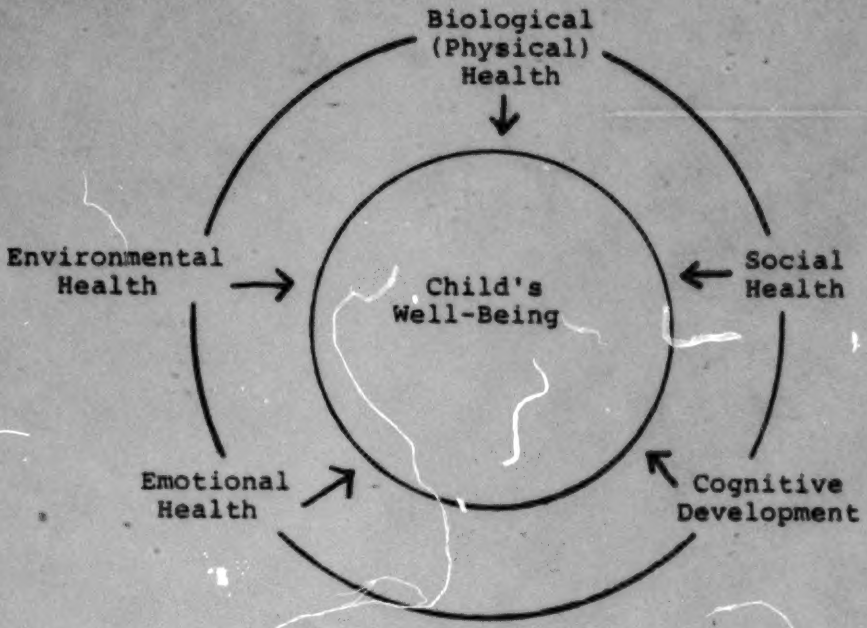
*For a list of HSI publications, contact the Home-School Institute, 3201 Newark Street, N.W., Washington, D.C., 20017, (202) 269-2371.

ARONSON LEADS GROUP DISCUSSION ON HOME-BASED HEALTH COMPONENT

Dr. Susan Aronson, Assistant Professor of Community and Preventive Medicine and Assistant Professor of Pediatrics, Medical College of Pennsylvania, Philadelphia, Pennsylvania, led a session on the Health Component in Home-Based Programs.

Describing health as "a state of well-being," she presented the following diagram as a useful way of looking at the various impacts on a child's state of health:


Biological (Physical) Health
Environmental Health
Child's Well-Being
Social Health
Emotional Health
Cognitive Development

Dr. Aronson listed the three major health and safety risks to children---i.e., things that endanger children's well-being---as follows:

1. Accidents (the "No. 1" killer and injurer of children after the newborn period)
2. Infections
3. "Quiet" conditions such as
   a. Nutrition deficits
   b. Dental problems
   c. Hearing loss
   d. Sight problems
   e. Environmental poisoning
   f. Developmental disabilities
   g. Hereditary diseases

Next, she showed some slides depicting the leading health and safety hazards (including deaths) to children in 1973, in order of frequency.

For children under the age of five and in the 5- to 14-year-old category, the three major causes of death were accidents caused by (1) motor vehicles, (2) drowning, and (3) fires and burns.

For children under the age of five, the next three leading causes of death were (4) choking (ingesting food and objects), (5) falls, and (6) poisoning.

For children in the 5- to 14-year-old range, the next five leading causes of death were (4) firearms, (5) falls, (6) choking, (7) poisoning, and (8) other causes.

Dr. Aronson discussed the significance and sources of infection as a hazard, specifically (in order of frequency of occurrence), respiratory, gastrointestinal, systemic, skin, eye, and urinary.

The next hazards discussed were what Dr. Aronson called "quiet conditions": nutritional deficits, dental problems, lead absorption, developmental disabilities, hearing loss, eye problems, and hereditary diseases. These problems interfere with a child's overall development. They are important targets for prevention, early detection, and intervention.

Dr. Margaret Phillips, Senior Nutrition Specialist, Head Start Bureau, Administration for Children, Youth and Families (formerly Office of Child Development), Washington, D.C., spoke next and emphasized that there is a great need for basic knowledge and basic skills in nutrition health. Some of the points she made included the following:

1. A variety of foods is the best nutrition "insurance."

2. There are four basic food groups; unless foods from all groups are eaten, some deficiencies in the trace elements (zinc and copper) may occur.

3. It is important to choose more whole-grained foods, such as whole-grained breads, crackers, and cereals, and to avoid white breads and processed foods.

4. Knowledge of the skills of proper food preparation can help in retaining most of the nutritional value of food.

5. It is helpful to learn to prepare foods in ways that avoid or reduce the use of fats and salt.

6. Home visitors can teach families to serve simple, nutritious snacks, rather than sweet, sticky, or salty ones.

7. Candies, cakes, and cookies with high sugar content should be avoided.

8. Families should learn the basics of proper food sanitation (e.g., washing, refrigerating, and storing).

9. The basics of proper food selection and buying should be emphasized.

10. We need to promote better weight control; 30 percent of the adult population is overweight, and children of overweight parent(s) have an 80 percent chance of becoming overweight, too.

Next, Ms. Vicki Dean, Training Coordinator, Clinch-Powell Home Start Training Center (HSTC), Harrogate, Tennessee, described the delivery of nutrition and health services in her home-based program. She noted that in her program home visits are made to each family, 1-1/2 hours each week. Once a month, the home visit is set aside specifically for a nutrition education lesson. The home visitor takes food into the home, helps the parent(s) identify various food groups, assists the parent(s) with preparation of a nutritious snack, and discusses the nutritional benefits of different foods.*

According to Ms. Dean, dental health is also a large part of nutrition education in the home visiting program. Parents also receive a handbook on seasonal foods, menu planning, consumer shopping tips, etc.

The nutrition assessment in the Clinch-Powell program consists of a pre- and post-evaluation questionnaire that assesses the children's nutritional status at various points in time.

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* The Clinch-Powell HSTC has developed an excellent guide for home visitors to help them plan and conduct the nutrition component in a home-based program. Copies of the "Parent's Guide to Good Nutrition" are available at minimal cost from: Clinch-Powell Educational Cooperative, Box 279, Tazewell, Tennessee 37879.

Ms. Dean also mentioned that the parents attend meetings and cook and eat nutritious meals together at the center.

Next, Ms. Susan Bradley, Home-Based Coordinator, Parkersburg, West Virginia HSTC, commented on dental care for families in her program, which serves very rural areas. She said that it was found that when children left the home-based program and entered public school, they no longer had access to proper dental care. So, to combat this problem it was decided to incorporate preventive dental care measures in the home visiting program. A consultant from the Health Resources Administration's Division of Dentistry was hired to conduct a 3-week, intensive dental workshop with staff on subjects such as proper brushing, disclosing, flossing, nutritional aspects of dental care, etc. The staff then worked with parents and children on these areas.

Ms. Bradley explained that families were provided with vitamins as well as fluoride tablets (for those who did not have access to fluoridated water), and were encouraged to use a calendar-type chart to record their taking of the pills.

To emphasize the severity of the problem in this area, Ms. Bradley stated that 80 percent of the program's Head Start parents have badly decaying teeth or none at all, which greatly alters their speech, among other things. She also stressed that good nutrition (including elimination of candy, cookies, sweet drinks, sugared gums, etc.) is a necessary ingredient in good dental care.

"After the consultant's training, our program launched a 4-month concentrated effort to get the families 'sold' on a routine of daily brushing, disclosing, and flossing," she said. "About 20 percent of the families were not faithful to the routine, so we asked the consultant to come back for some follow-up training, and another 4-month 'attack' was launched. Things progressed better this time---so much better that the children were beginning to take responsibility for their own dental care and started reminding their parents about vitamins or fluoride tablets, etc."

Next, Ms. Rose Schneider, Health Specialist, ARVAC, Inc. HSTC, Russellville, Arkansas, told participants that home visitors must be sensitive to the fact that preventive health care is not a part of the lifestyle of some members of the population.

"Sometimes, home visitors must learn to work gradually to introduce the concept of early and periodic screening, diagnosis, and treatment," she said.

Among other points Ms. Schneider made were that:

1. Home visitors should be trained to perform proper assessments of individual health needs of family members.

2. Home visitors should be trained in how to approach effectively the subject of health issues with families.

3. Home visitors should be trained in preventive health measures.

4. Home visitors must be trained to know where to obtain proper health information and how to communicate this information to families.

5. Home visitors need training in interpersonal communication skills, specifically, listening to families describe their health needs and questioning in a sensitive manner.

6. Home visitors must be "sold" themselves on preventive health care before they can convince parents of the need for it.

Ms. Schneider then turned to the subject of mental health. She noted that in rural Arkansas, if one has mental health problems, he/she is perceived to be "crazy," and families fear ostracism and shame if they admit to mental or emotional problems. She explained that the ARVAC program attempts to encourage the practice of preventive mental health as well as preventive physical health.

"Our home visitors try to help parents develop positive self-images and feelings of self-worth," she said. "We believe that stroking can be a powerful motivator, because people (parents) need to know when they are doing a good job. Stroking can lead to positive feelings about one's ability to cope."

The rest of the session was devoted to reactions from two "reactor panelists," Ms. Laverne Beaty, Home Visitor, ARVAC, Inc. HSTC, and Ms. Hazel Bright, Home Visitor Trainer, Clinch-Powell, Tennessee HSTC, as well as a question-and-answer period.

WORKING WITH HANDICAPPED CHILDREN IN HOME-BASED PROGRAMS

Six panelists, representing a wide spectrum of experience with handicapped children, discussed a number of discrete aspects of services to such children in a home-based (Home Start-type) program.

The session was chaired by National Home Start and Child and Family Resource Program Director, Dr. Ann O'Keefe, who told the audience that about 20 percent of all children now served in a home-based option are classified as "handicapped," in contrast to the overall Head Start program, in which about 12 percent are classified as handicapped.

The first panelist then began with a brief discussion of five basic problems faced by parents of handicapped children. Dr. Rosslyn Gaines, a professor at UCLA's Medical School and Department of Psychology, and herself the parent of a multiply handicapped child, told the audience that there are some facts which---unpleasant though they may be---must be faced and acknowledged before a realistic, sensitive, and effective program can be developed. For example, she said that nobody really hopes to have a handicapped child; parents often feel guilty about having had a handicapped child; parents know that the child will not do as well as nonhandicapped children in many respects; there is often a cultural aversion to handicapped individuals; and there is not a full or adequate social community for the handicapped.

Dr. Allana Elovson, Director of the San Diego Home Start program, then discussed seven specific ways in which a home-based program can assist parents and their handicapped children---depending, of course, on factors such as the age of the child, size of family, and other family considerations. She said that the home visitor can:

- both help the family detect the handicap earlier, and then help the family understand the handicap and what limitations it does---and does not---actually impose;
- help parents "work through" their feelings about the child by listening and being supportive;
- get a good picture of the parents' present actual ability to help their own child;
- see what resources are available to help the family;
- link families with resources (which can be especially important for families who are isolating themselves because of their special problem);

- demonstrate the acceptability of the child by accepting the child herself. (Dr. Elovson said that in some cases, the very fact of the home visitor's willingness to come in close contact with the child is an immense morale booster for the parents.)

- help families interpret medical findings, and follow medical instructions for follow-up treatments in the home.

Ms. Nelda Kopp, Handicapped Specialist for the Reno, Nevada Adult Focus Home Start Training Center and also the parent of a handicapped child, focused her presentation on how to help parents by using articles and information readily found in newspapers, magazines, articles, and books. She gave many examples of how such media often contain material that will help parents develop new perspectives on their own particular problems, or will provide helpful leads to new resources.

Ms. Marilyn Long, Training Coordinator for the Millville Home Start Training Center, Millville, Utah, described how her HSTC uses the Exceptional Children's Center, affiliated with Utah State University, Logan, Utah, as a training resource to help familiarize trainees (usually staff in home-based programs) with ways of serving handicapped children and their families when they become part of a home-based program.

Next, Mr. David Shearer, Director of the Portage, Wisconsin Home Start Training Center and of a training program funded by OE's Bureau of Education for the Handicapped, warned the audience of some "traps" or pitfalls to attempt to avoid. He recalled the "near-panic" expressed by some Head Start programs when the Congress mandated that handicapped children account for at least 10 percent of Head Start's population; but, at the same time, he reminded participants that some Head Start programs had been including handicapped children prior to the mandate, and that there was a foundation on which to help staff build their competence and confidence related to handicapped children. Mr. Shearer urged the audience not to fall into the "label" trap of letting the label determine the child's curriculum, but rather to let the child's needs determine the curriculum. He also cautioned participants about the "inadequate parent syndrome" in which the child's problem is presumed to be caused by the parents' problem.

"Don't make assumptions about parents of handicapped children," he told the audience. "What parents want most to know is how they can help their child."

He recommended three basic steps to help guard against these "traps": assessing the child and his/her situation, determining available resources, and planning the basic developmental steps that need to be taken for the individual child. (Mr. Shearer recommended a task analysis approach for this planning and explained how behavioral objectives can be helpful when they are realistically determined.)

Ms. Clara Paige, Director of the Norfolk, Virginia Head Start program, illustrated her presentation with a number of slides showing how handicapped children are incorporated into her Head Start program. She emphasized the importance of explaining the program to parents, some of whom may have unrealistic expectations about what the program will do for their child. She showed slides of a number of materials which home visitors actually take into homes, and explained how home visitors can help parents learn to carry out doctors' orders (for exercises, etc.) in the home. Helping children in the Head Start center learn to accept their handicapped peers is another important thrust in Ms. Paige's program, because the program's strategy is to begin with a home-based approach, but eventually to move the child into more and more center activities until he/she is eventually fully phased into the center-based program. The book developed by her program, Give The Handicapped a Head Start, also has many suggestions for implementing a program such as the one in Norfolk.

To conclude the session, Dr. Gaines discussed a number of recommendations aimed at helping programs improve their services to handicapped children. (As a consultant to the former OCD---now, the Administration for Children, Youth and Families, Dr. Gaines visited a number of Head Start programs in 10 separate geographical locations, to describe services for the handicapped and to distill from her experience basic recommendations for improving services. Although her recommendations spanned a number of areas, such as identification, diagnosis, and treatment, she confined her remarks to recommendations bearing on parent involvement because she felt this is a most important area and in need of the most strengthening.) The six recommendations Dr. Gaines made to the audience were:

1. Staff must develop even greater respect for parents and what parents have to offer their own handicapped child. She stated that often a parent does become "the expert" on certain matters pertaining to his/her particular child, and staff should be sensitive to, acknowledge, and use this expertise.

2. There should be someone in every Head Start who functions as a Child and Family Advocate. The advocate would make available whatever time it takes to develop a good relationship with the parent, and to protect the child from being stigmatized by his/her label. Dr. Gaines mentioned that labels are intended to serve the child, and---among other things---the advocate would see to it that they do.

3. Parents need more information, and programs should make all appropriate information readily available.

4. Parents need counseling for themselves, particularly in times of family or personal stress (or crises). These stresses almost always reflect back onto the child, she said.

5. Parents need knowledge of the basics of child development, so they will understand the parameters of normal growth and development.

6. Parents need models, i.e., people, to show, by example, what to do with the child. Parents need people to respond to them as people, rather than as parents of a handicapped child.

Because parents in fact provide the long-term year-in/year-out continuity for their children, Dr. Gaines closed by emphasizing that all efforts made in behalf of parents are likely to have direct benefits on their children.

CONFEREES HEAR SUGGESTIONS ON HOW TO MAKE EPSDT WORK

One session of the conference was entitled Early and Periodic Screening, Diagnosis, and Treatment: How to Make It Work.

Dr. Linda Randolph, Director of Health Services, Head Start Bureau, Administration for Children, Youth and Families (formerly Office of Child Development), Office of Human Development Services, Department of Health, Education, and Welfare, Washington, D.C., said that the EPSDT program is a "State-operated program with matching funds and is therefore as diverse as the States that have programs."

She noted that EPSDT is the "largest single resource available to Head Start children and their siblings and others in the community," and said that Head Start is a direct provider of health services which can use EPSDT to fill gaps for services by advocating for children.

Mr. Paul Phelan, Head Start State EPSDT Coordinator, Lancaster, Pennsylvania, cited problems such as an insufficient number of doctors willing to provide screenings, lack of transportation to services, and inability of programs to receive results.

"My initial job was to start working with the State government, which had an EPSDT State task force and invited me to be a member," he said.

Commenting that dental care is still a major problem in a lot of areas, he noted that Pennsylvania will soon have a dental van to travel around the State. He also said that a major breakthrough has been made in getting results back, in that now there is a form which all Head Start programs in the State will receive.

"A number of the successes in our State are due to the task force, which has Head Start representation," he concluded.

Next, Ms. Yvonne Ali, EPSDT Project Director, National Child Day Care Association, Washington, D.C., stated that she is working with Head Start centers and public schools in a demonstration program "to see how to get to parents through children in these settings." She said that the program staff try to find community resources to do the screening so that blocks of time can be set aside for children to be taken to various community agencies to receive different benefits of EPSDT.

Ms. Ali noted that dental care services pose a problem even in a city as large and resource-rich as Washington, D.C. Out of 3,700 children, over 90 percent had more than four cavities and many required orthodontal work for which EPSDT would not pay, but now Howard University is providing this service for a small fee, she said.

Regarding developmental assessment, Ms. Ali commented that she feels elaborate screening devices are unnecessary and that teachers can perform the screening by using observational forms with most of the children.

"The inner city breeds emotional problems with children," she said. "Therapeutic classes are needed where some children with behavior disorders can go at times during the day for special treatment."

Next, Ms. Mary O'Connor, Head Start Project Manager, Community Health Foundation, Evanston, Illinois, told participants that a companion guide to "Recipes for Success" will be published soon.* She gave the following suggestions for local personnel interested in EPSDT:

1. Generally, a State agency (usually either the health or welfare department) is responsible for EPSDT. Most States have State coordinators who can refer people to local resource personnel knowledgeable about forms needed, services available, and schedules.

2. It is important to find out who is eligible and what providers of health services parents are currently using. (The Welfare Department has a list of providers whom local personnel can contact.)

3. Local personnel should ask that providers be available to siblings and available to children after they have left Head Start.

4. Local personnel should help with the scheduling of appointments so that providers do not have to endure a high incidence of broken appointments.

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* It will be available from: Marian Slatin, Administration for Children, Youth and Families, Office of Human Development Services, Department of Health, Education, and Welfare, P.O. Box 1182, Washington, D.C. 20013, 202/755-7944.

5. Local staff should have direct contact with the people who provide services.

6. Parents should be able to get copies of their children's records.

Regarding the last point, Dr. Randolph noted that the Privacy Act does not apply to grantees nor does it apply to the private sector; thus, any child's records can be transmitted as long as there is parental consent. She emphasized the importance of providers having access to detailed records and information and said that it is not necessary for programs to have the actual records as long as they have general results and access to detailed records. She also stressed that at the time of recruitment, program staff should start reminding parents about the importance of health services.

PRESENTERS PROVIDE HIGHLIGHTS OF BILINGUAL-BICULTURAL PROGRAMS

In a session entitled Overview: Head Start Strategy for Spanish-Speaking Children, presenters reported on the status of bilingual-bicultural programs presently funded by the Administration for Children, Youth and Families (formerly the Office of Child Development).

Ms. Soledad Arenas, Education Specialist, Head Start Bureau, ACYF, Washington, D.C., began by noting the four areas which ACYF has emphasized in such programs: curriculum, staff training in bilingual-bicultural skills, research, (to understand how children acquire their first and second language), and a technical assistance delivery system.

Dr. Gloria Zamora, Director, Bilingual-Bicultural Curriculum Project, Intercultural Development Research Associates, San Antonio, Texas, described the Amanecer curriculum model for use with Head Start children. The model is currently being developed and will be tested in various Head Start sites.

According to Dr. Zamora, the finished package will include English and Spanish versions of materials on how children can be motivated to learn, as well as filmstrips and cassette tapes emphasizing skills teachers should be learning.

"New concepts and ideas should be presented to a child in the language he/she knows best," said Dr. Zamora. "A new idea in a new language represents NO learning."

She said the curriculum will include sections on how a child grows and learns; how to stock the classroom; "people talk" (language and cognitive development); and learning environments, circle time activities, culturally oriented holidays, etc.

Next, Mr. Robert Medrano, Director, Bilingual-Bicultural Child Development Associate program, Texas A & I University, Kingsville, Texas, described his program which serves bilingual trainees in 15 counties in south Texas. He noted that all children with whom trainees work are Mexican-American, monolingual Spanish or bilingual migrants. He cited the following as special problems encountered by his program:

1. Many migrant teachers do not qualify for college.
2. Many teachers are migrants themselves from the Texas Migrant Council which requires that teachers follow migrant children.
3. Many families start migrating in April, and college is not finished until May.

4. The program covers a vast area; site supervisors often have to travel several hundred miles to make site visits, and travel and per diem costs are expensive.

5. Husbands of both trainees and staff prefer to have their wives home at night rather than involved in educational activities or night classes in off-campus sites.

Despite these and other problems, however, Mr. Medrano told participants that 11 candidates were assessed last year and 19 this year.

In the area of curriculum development, he said that 18 modules derived from 13 functional areas will have filmstrips and cassette tapes in Spanish and English. The demonstration test in each module is based on self-assessment and supervisor assessment.

Next, Dr. Arlene Sutton, Director, Bilingual-Bicultural Resource Network, Interamerican Research Associates, Denver, Colorado, spoke about processes for delivery of services to Head Start programs for training and technical assistance (T&TA) to bilingual programs.

She stated that the resource network has two major objectives: providing bilingual-bicultural materials and providing T&TA to help programs today, before new materials are available.

JOHNSON LEADS DISCUSSION ON WAYS OF INCREASING AND IMPROVING PARENT INVOLVEMENT

Mr. Richard Johnson, Social Services and Parent Involvement Senior Specialist, Head Start Bureau, Administration for Children, Youth and Families (formerly Office of Child Development), Office of Human Development Services, Department of Health, Education, and Welfare, Washington, D.C., chaired a session entitled Increasing and Improving Parent Involvement in Head Start. He told participants that in the past few years the Head Start program has placed more and more emphasis on involving parents in the program.

The first panelist was Mrs. Sylvia Carter, Parent Coordinator, Head Start Regional Resource Training Center, University of Maryland, College Park, Maryland. She emphasized the importance of planning in any parent involvement program. She also stressed that programs should actively recruit parents and tell them exactly what they are required to do as well as what they will benefit from as a result of the program.

She recommended that program orientation be locally designed, that it include program goals and strategies for accomplishing goals, and that it be fairly formal.

"The time and place of the orientation session should be well planned so that the parents have an adequate opportunity to attend the meeting and be comfortable," she said. "For example, weather conditions should be considered, as should factors such as how many of the parents are working."

Ms. Carter noted that the orientation meeting need not be held at the Head Start center, but can take place anywhere. She stressed the importance of including parents in the planning stages as well as providing support services for them to attend the meetings and appropriate follow-up after the meetings.

Ms. Rhonda McLean, Parent Coordinator of the Learning Institute of North Carolina, in Greensboro, cautioned participants not to be limited by performance standards as to what parent involvement will mean in a specific situation. She said that the main reason for parent involvement is to obtain the support of the entire family for Head Start goals.

Noting that the "best" parent involvement includes situations in which teachers have personal interaction with families, Ms. McLean said she had observed six different types of parent involvement in Head Start programs: (1) parents participate as an audience---i.e., the program sends them information and materials and explains to them that the school is theirs; (2) parents act as a reference---i.e., assessments of parental skills and strengths are conducted; (3) parents are teachers---mainly in the home; (4) parents participate as volunteers; (5) parents are involved as staff members; and (6) parents act as policymakers, receive progress reports, visit the school, etc.

As for some tips on preparing parent involvement programs, Ms. McLean advised: know what you mean by parent involvement, establish trust, never give up, try new and daring things, and be sure that staff and parents get the information they need.

Dr. Goodrun Wicklund, Head Start Leadership Development Program, Texas Southern University, Houston, Texas, said, "The name of the game is the parent as teacher and contributor. It is of the utmost importance that the system of parental involvement fit the specific situation."

Dr. Wicklund said that parents are the primary educators of their children and that, due to changes in lifestyles, parenting principles that most people learned from their parents are no longer applicable and new ones must be learned.

Dr. Wicklund also stressed that it is not necessary for parents to have a lot of things or toys to teach the child, but that many items found in the home can be used to reinforce what the child is learning at school.

The next speaker was Dr. Mary Tom Riley, Head Start Regional Training Officer, Texas Tech University, Lubbock, Texas. Describing the LATON program her organization established for handicapped children in Louisiana, Arkansas, Texas, Oklahoma, and New Mexico, she said she works especially with parent involvement for parents of Head Start handicapped children and then showed a film entitled "LATON" on the subject.

The final speaker, Dr. Arnita Boswell, Associate Field Work Professor, University of Chicago, School of Social Service Administration, Chicago, Illinois, spoke of the need for commitment by teachers to the teaching field and reiterated the concern expressed by all panel members that there is a need for more parents to speak out on matters that involve them and their children.

IMPORTANCE OF PARENT EDUCATION IS EMPHASIZED

In a session entitled Issues in Parent Education, six speakers discussed issues surrounding parent education in comprehensive child development programs.

Mr. Richard Johnson, Social Service and Parent Involvement Senior Specialist, Head Start Bureau, Administration for Children, Youth and Families (formerly Office of Child Development), Office of Human Development Services, Washington, D.C., introduced several topics for discussion. He spoke first of where administrators should begin in developing parent education activities. He stressed the importance of developing programs with parents, and not necessarily for parents.

Ms. Ruth Rucker, Director, Washington, D.C. Parent Child Center, said, "Programs should be based on parents' feelings as to what needs to be done. Administrators should not attempt to interpret what is best for parents."

Remarking that parents differ in backgrounds, knowledge, and needs, she mentioned that the area of assessment is extremely important and that parent needs must be identified before programs are planned.

Dr. Peter Haiman, Development Associates, Inc., San Francisco, California, commented that administrators do not always know what programs will best serve parents at any particular time. He stated that administrators "have to deal with parents first and recognize their adult needs."

Ms. Frankie Gibson, Parent Coordinator, Wichita Child Day Care Association, Wichita, Kansas, noted, "Very often our emphasis tends to be on how we can get parents to be involved. We need to spend more time strengthening the family concept."

Dr. Earl Schaefer, Professor, Maternal and Child Health, University of North Carolina, Chapel Hill, North Carolina, stressed the importance of working with parents in developing program curricula and commented, "We as administrators must show parents alternative ways of achieving their goals, once those goals have been determined."

On the subject of staff concerns, Ms. Rucker emphasized the importance of choosing "good" people to work as staff members. She noted that staff members' attitudes often filter down through the parents to the children and that staff members must be able to relate to, and be sensitive to the needs of, parents.

"Too often there is a lack of communication between the staff and the parents," Mr. Johnson said. "Staff members need to listen to parents and develop better communication skills."

Dr. Kellene Bruce, Project Director, Roy Littlejohn Associates, Inc., Washington, D.C., added that more staff training is necessary to increase the sensitivity of the staff to the parents.

"All too often one staff member ends up with all the weight of caring for the parents' needs," Dr. Bruce said.

Regarding the tendency of administrators to approach the problem from a pathological standpoint, Dr. Bruce asserted that too often programs and staff members concern themselves with the negative aspects of family life and suggested that administrators should start emphasizing the positive aspects.

Mr. Johnson next turned the discussion to the concept of packaging parent education programs---e.g., how long a program should be, what kind of materials should be used, what information parents should be given, etc. He said he felt that program planning and timing should be geared to the expressed needs of the parents and that program content should be flexible so that the needs of the parents could be best served.

Dr. Bruce stressed the importance of selecting materials which will stimulate discussion and interaction among parents. Expanding on this, Dr. Haiman recommended that parents be allowed to select topics which interest them. He remarked that this would give parents an option as to what they feel they need to know and would let parents control the kinds of topics discussed.

Ms. Rucker contended that staff members should make home visits in order to have a better idea of what is happening within a particular family and more familiarity with the family structure.

Turning to the subject of parenthood education, Dr. Bruce stressed the need for people to "know what parenting is all about" before they are faced with becoming parents.

Reinforcing this, Dr. Schaefer added, "Educators should start preparing people for parenthood when they are in grade school. People talk about the three 'R's'---well, I think there should be four 'R's'---reading, writing, arithmetic, and rearing."

Dr. Haiman agreed that people should start learning about parenthood at an early age, and said, "The role of men in this society has inhibited child rearing." Calling for adolescent boys to be educated in the care and nurturing of children, he labeled the male personality in our society as a "mental health problem."

In summary, Dr. Schaefer emphasized the need for (1) administrators to start taking a positive approach in working with a family (instead of "diagnosing the negative problems"); (2) development of a community-parent group relationship for "group power;" and (3) involvement of parents in solutions to administrative problems, both within the program and the family.

LAPIDES FOCUSES ON "T.A." AS FRAMEWORK FOR HELPING PARENTS TO HELP CHILDREN

In a session on Helping Parents to Help Children, Mr. Jerry Lapides, Director of Mental Health Services, Head Start Bureau, Administration for Children, Youth and Families (formerly Office of Child Development), Washington, D.C., discussed the role that "existential positions" (as the late Dr. Eric Berne called them) or attitudes play in helping to explain parental views toward the special child and toward the special education worker.

He noted that early experiences (including messages, orders, and attributions given to them by their own parents; recognition they received; and behavior and feelings which were ignored or put-down) were translated by the parents when they were children into a self-concept which was applied first personally and then extended to others.

Commenting that the existential position is explained by two continuums, one extending from "okayness" or a high sense of acceptance to "not okayness" or a low sense of acceptance, and the second traveling from "I" to "Thou," or a view of oneself to a view of others, Mr. Lapides defined the four basic positions of Transactional Analysis.

Popularized by Thomas Harris, M.D., in his book _I'm Okay, You're Okay_, these positions included:

1. "I'm OK, You're OK" (accepting, healthy position whereby acceptance of self and others is high and is based on reality rather than a euphoric, "Pollyannaish" view of the world).
2. "I'm OK, You're Not OK" (hostile, holier-than-thou position whereby the self is viewed as good and wise and any internal low self-concepts are projected onto others).
3. "I'm Not OK, You're OK" (a depressive, self-abasing stance whereby one's self is not considered worthy, so others are looked to for guidance and direction).
4. "I'm Not OK, You're Not OK" (futile, hopeless, despairing position).

Dr. Berne later expanded this concept and added a third party to one's sense of acceptance--e.g.," I'm OK, You're OK, They're OK." Mr. Lapides noted that it is in these "three-handed" positions that Dr. Berne's work becomes meaningful in analyzing the attitudes of parents toward their handicapped or gifted children and those who serve them. (Conversely, the same exploration can be made of the special education worker's view toward special children and their parents). From this perspective on attitudes, eight positions become apparent:

1. I'm OK, You're OK, They're OK.
2. I'm OK, You're OK, They're Not OK.
3. I'm OK, You're Not OK, They're OK.
4. I'm OK, You're Not OK, They're Not OK.
5. I'm Not OK, You're OK, They're OK.
6. I'm Not OK, You're OK, They're Not OK.
7. I'm Not OK, You're Not OK, They're OK.
8. I'm Not OK, You're Not OK, They're Not OK.

Mr. Lapides commented, "We must look at these eight positions as we do at two sides of a coin, with 'I' representing the parent as well as 'I' representing the worker. Too often, the parents blame the child and the program and the workers blame the parents or the child."

Regarding Position 1, Mr. Lapides cautioned participants to remember that no one has all the answers, that teachers and parents should "meet" but that teachers often need to start the process, and that children should have regular periodic evaluations.

With respect to Position 2, he warned that there is no quick overnight solution, that parents and professionals must cooperate, and that professionals must open the door for communication.

Third, Mr. Lapides said, "Develop trust, don't become defensive, accept the present, and be aware of whose needs you're trying to meet."

Finally, there may be extenuating circumstances affecting attitudes. For example, the father may be pressured by societal and financial burdens; he may be defensive and angry, and he may have had previous experiences in which the professionals blamed him or listened to his dilemma and then changed the subject.

"Obviously, the variety of potential 'positions' is greater among parents than professional workers," Mr. Lapides said. "This may be due to their differing circumstances. The worker has a choice in his or her profession and usually will not enter or remain in a helping profession unless he/she feels a genuine empathy toward his/her clients. Parents of exceptional children, on the other hand, have no choice. They are literally handed a child with a special condition. In such stressful situations, the parents' basic sense of acceptance toward self and others is immediately revealed, and there is no real opportunity for them to make the child different than he is."

He explained that Dr. V.S. Somers has identified five distinctive categories of parents' attitudes toward children with special needs:

1. Acceptance (I---the parent---am OK; the child is OK; the worker is OK). In this position, the parent has objectively accepted the handicap and shows genuine devotion to and high evaluation of the child. No apparent guilt feelings or rebellion against the handicap are expressed.

2. Denial (the parent is OK; the child is OK; the worker is not OK). The parent denies that the child is actually handicapped and that the handicap has an emotional effect on the parent. Educational plans for the child indicate that the parent does not accept any limitations for the child.

3. Overprotectiveness (the parent is OK; the child is not OK; the worker is OK). Here, the parent needs the child to feel OK. Parents are overwhelmed by a feeling of pity which is manifested in oversolicitous and overprotective handling of the child.

4. Disguised rejection (the parent is not OK; the child is not OK; the worker is OK). In this instance, the handicap is considered a disgrace. The negative attitude and resentment toward the child are concealed by oversolicitous concern about his welfare and by exaggeration of the "duty" of being good parents.

5. Overt rejection (the parent is OK; the child is not OK; the worker is OK). In this position, the child is openly resented and the parent is aware of hostile feelings but builds up defenses to justify them. Society, the doctor, or teachers are blamed for being prejudiced against the handicap.

The session then broke up into small groups to discuss five things children need to mature and five things parents need to maintain optimal happiness. The consensus, for both children and adults, was: nurturing; loving relationships; opportunities to produce for approval or gain; approval of peers, colleagues, etc.; and time to be alone.

Following this, the groups participated in role playing interview situations and a discussion of ideas and feelings was generated.

WICHITA PARENTS AND STAFF ENTHUSIASTIC ABOUT 'EXPLORING PARENTING' CURRICULUM

Dr. Kellene Bruce, Project Director, Roy Littlejohn Associates, Inc., Washington, D.C., chaired a session entitled Exploring Parenting: A New Head Start Parent Education Curriculum. Dr. Bruce began by describing this new parent education curriculum. Known as "Exploring Parenting," the curriculum was developed by Roy Littlejohn Associates, Inc., Washington, D.C., for the Administration for Children, Youth and Families (formerly Office of Child Development), and is currently being field tested by 20 Head Start programs. Dr. Bruce noted that the materials for the curriculum were adopted from Exploring Childhood, a curriculum developed for the Education for Parenthood program by the Education Development Center in Newton, Massachusetts.

Following Dr. Bruce's opening remarks, Ms. Frankie Gibson, Parent Coordinator, and Ms. Elizabeth Goetz, Education Coordinator, Wichita Child Day Care Association, Wichita, Kansas, described how the curriculum has been used in Wichita, one of the 20 field test sites.

They noted that first an orientation was given to many parents in which the roles and responsibilities of staff and parents who might become involved in the project were explained.

A total of 20 Head Start parents participated in the project for 14 weeks, they said. These parents met once a week for two hours to discuss and learn about the various aspects of rearing children. They represented a diversity of cultures, ages (22-60), family sizes (1-15 children), and family types (some single parents, some two-parent families, and some extended families).

Ms. Goetz told participants that these parents were encouraged to keep a journal or diary of everyday events which they could share with others if they chose to do so. She said that resources and materials were gradually built up in looseleaf notebooks. The curriculum also consisted of printed handouts and "rap sessions" in which the parents shared their ideas or problems with the group.

"The curriculum is built around the philosophy that you must first feel good about yourself before you can relate to others in a positive way," she said. "It is a good mental health program."

Wichita staff members explained that a site consultant was assigned to the project and babysitting was made available for parents as needed. Expansion is planned for the fall of 1977 to include the parenting class in all Head Start centers, and staff training is being given for group leaders, some of whom may be parents who have already participated in the project.

Several parents from the Wichita program participated in a panel discussion about the program. Ms. Jennifer Buckley, Ms. Gloria Persyn, Ms. Bette Leggins, and Ms. Glenda Wilcox made the following comments about the program:

> "The project made us feel as parents that we could share with the group what we wanted to share."

> "The journal was very helpful toward gaining insight into myself and my family."

> "As a parent, I needed to understand my children. Other parents helped me work out my problems."

> "I discovered my children's individual needs as well as my own needs."

> "I learned to express feelings of anger and happiness."

> "I gained knowledge of growth and change that is needed at all age levels."

> "The session on stress and ways to express myself more positively was helpful."

"As parents, we noticed a change in the behavior of our children because of our own behavior change."

In the question-and-answer period, presenters related that ACYF furnished program materials, while the local programs furnished resource people for the field testing. The curriculum is not available to Head Start programs at present; now that the field testing is completed, information from all 20 sites will be gathered and decisions made regarding the next steps.

The ACYF program director for the Exploring Parenting effort is Mr. Richard Johnson, Senior Specialist for both the Parent Involvement and the Social Services components within the Head Start Bureau.

PANELISTS PRESENT POTPOURRI OF PROGRAMS FOR PARENTS AND THEIR BABIES AND TODDLERS

A special Office of Education-funded TV series on parenting was described by Mr. Jerrold Sandler, Executive Program Director, Parent Education and Television Program, Applied Management Sciences, Silver Spring, Maryland.

According to Mr. Sandler, the series of 20 half-hour TV programs, scheduled for release in January 1979, has as its goal "to enable parents to facilitate the growth and development of their children through:

1. Development of positive attitudes toward parenting (including learning about children's development, and how to take an active role in their learning).
2. Growth in knowledge and understanding of children's development.
3. Development of skills which help parents deal with everyday experiences related to children.
4. Development of autonomy and self-confidence as parents."

Mr. Sandler noted that the target audience will consist of adults from age 17 to 25, and that the format will include a dramatic case study approach utilizing five families of various ethnic backgrounds. The half-hour dramas will be combined with documentary-style information on child development and appropriate alternatives to solving each problem situation depicted in the drama.

He said that program themes will include subjects such as helping children develop self-discipline; the need for early stimulation; forming nutrition habits; parenting styles; prenatal preparation for parenthood; and dealing with crises.

The next speaker, Ms. Zoe Smith, Community Research Specialist, Bismarck Early Childhood Education Program, Bismarck, North Dakota Child and Family Resource Program (CFRP), spoke of ways in which programs such as CFRP can help parents with their roles as prime educators of their children.

Ms. Smith focused on two major areas: (1) staff credibility in terms of relating to children with warmth, acceptance, and love, as well as an understanding of developmental levels and the ability to handle disruptive behaviors calmly and tactfully; and (2) curricula and information developed by people such as Jean Piaget, Erik Erikson, Burton White, Ronald Lally, and others.

Ms. Smith suggested that staff members choose curricula, films, questionnaires, scales, etc. with which they are most comfortable and begin to implement this information slowly and gradually in working with families.

She suggested that handouts (such as social competence scales) and certain techniques (such as videotaping infants) often stimulate parents to participate more in the program with their children. She also mentioned that songs, crafts, and provision of a stimulating environment for play and an opportunity for parents' discussions often contribute to good programs for parents and their babies and toddlers.

Next, Dr. Donald Pierson, Director of the Brookline Early Education Project, Brookline, Massachusetts, told participants that there are six questions commonly raised regarding his project:

1. Who participates? The Brookline Project is reaching "those families who would benefit most." However, Dr. Pierson pointed out that it is impossible to identify the population accurately and said, "Labeling is not desirable beyond the fact that infectious enthusiasm is healthy and should be coupled with active community outreach to families who would not otherwise hear or know about the program."

2. When does the program start and how long does it last? Dr. Pierson said the program starts in the prenatal period and lasts through the preschool years. He noted that his staff has found that children learn rapidly in the early years and that those parents who enroll in the prenatal stage of the program establish greater rapport with the staff in the succeeding years of the program.

3. What services does the program include? Dr. Pierson explained that the Brookline program provides mainly health and education services, including drop-in child care, group gatherings and meetings, and home visits.

4. How are teachers selected, trained, and supervised? Dr. Pierson responded that the Project's teachers are truly empathetic with the parental role and are, in fact, parents themselves. He commented that it is also important to have clear curriculum guidelines and teaching styles. Regarding supervision, he noted that the Brookline Project uses a team approach in which both staff and parents provide feedback so that an open-door

growth policy can be maintained.

5. In general, what is the health professional's role? Dr. Pierson said that there is increasing evidence that health (i.e., medical) concerns do not go unnoticed or untreated during the early years. However, he added that often pediatricians fail to address child development stages adequately with parents and stressed that they (i.e., health care professionals) have an obligation to become more informed in this area.

6. Generally speaking, what is the role of public schools? Dr. Pierson emphasized that until the interest and commitment of the school board is gained, long-range implementation and follow-up will be lacking. He mentioned that personnel such as librarians, school health personnel, and guidance counselors can be utilized more effectively if the public schools work closely with early education from the outset.

With respect to the Brookline Project's evaluation, Dr. Pierson told participants that 285 families with children born in 1973 and 1974 were evaluated, based on their assignment to three cost levels within the program: (1) frequent home visits (most expensive); (2) less frequent home visits (moderately expensive); and (3) no scheduled meeting with the staff (least expensive). He stated also that children's health, growth, and development were being compared at four points in time: 14-1/2 months, 30 months, kindergarten, and second grade.

With regard to whether the program has enhanced health and development in prekindergarten years, he said that available data indicate no difference between groups at 14-1/2 months of age.

Concerning the response of participating parents, most families have continued with the program; only 10 percent have dropped out, and all but four of these families moved. Dr. Pierson said that families report that they value the program and are now more effective consumers of, and advocates for, child health care and services.

He also commented that questions such as whether the program has a lasting impact on participating children and what its impact is on schools and the health community are being studied.

As to a process or descriptive evaluation noting factors important to successes of particular families, Dr. Pierson suggested the use of a project historian, staff notes, and frequent interviews with a cross-section of families to supplement outcome data.

The last speaker, Dr. John Love, Project Director, High/Scope Educational Research Foundation, Ypsilanti, Michigan, provided an overview of the Ypsilanti Infant Education Project which has been conducted since 1968 for 3- to 9-month-old infants. This program emphasizes the use of home visitors who provide assistance to parents in reaching self-determined goals.

According to Dr. Love, an attempt is made to develop an open problem-solving approach which emphasizes the individuality of the parents and each participant's potential as a resource for others. He noted that information sharing among parents, equal responsibility for goals, and emphasis on individual and cultural/linguistic differences are all important aspects of the program.

Dr. Love commented that the home visitor's role is to help the parent(s) recognize and state family goals for child development and develop the capacity to meet these goals. He stressed the importance of the home visitors' respect for the parents and the integrity of the home. He concluded by stating that written materials and films on the project are available through the High/Scope Educational Research Foundation, 600 North River, Ypsilanti, Michigan 48197. (313)485-2000.

DIANE BLACK RELATES EXPERIENCES IN WORKING WITH TEENAGE PARENTS

Ms. Barbara Providence, Coordinator, New Haven, Connecticut Child and Family Resource Program, chaired a session entitled Working With Teenage Parents in which Ms. Diane Black, Mental Health Consultant, Oakland, California, related some of her experiences as director of a Seattle, Washington program dealing with teenage parents.

Ms. Black mentioned that teenagers are going through certain physical changes which create a great strain on them and which they sometimes do not understand themselves. Noting that one-half of all teenagers suffer from malnutrition because their diet consists of "fast food" items, she commented that this results not only in their not having enough energy to perform the work assigned to them but also in carrying the diet over to their children---e.g., some young girls give their babies drinks such as Kool-Aid and classify it as juice.

She also remarked that in the area of psychological development, since their egos are undergoing drastic changes, teenagers often have a hard time coping with other people. When their infants are first born, young mothers are fascinated and relate to the children as they would to dolls. She stated, however, that this stage generally lasts only about a month and then the mothers begin to have problems.

According to Ms. Black, another problem faced by teenage mothers is that they "lack knowledge of their own sexuality." When asked how they feel and function or how they relate to being a female, they are at a loss to explain, she said.

Ms. Black told participants that the average age of the mothers in the program she directed was 15, but she said she felt that this was only because they were in a high school, and that if the program had been conducted in a junior high, the age would have been lower.

She cited as problem areas getting the mothers to attend classes after the first month of the babies' lives when the novelty had worn off, and the fact that the girls lived with so many different people (ranging from grandmothers to friends).

In conclusion, Ms. Black said that there is no "magic solution" to the problems of teenage mothers but that she was proud that all 30 girls in her program graduated from high school.

PRESENTERS QUESTION 'MYTH' OF INDEPENDENCE, HIGHLIGHT SPECIAL NEEDS OF ADOLESCENT PARENTS

Some programs, such as the Child and Family Resource Program and Parent Child Centers, are working increasingly with adolescent parents. A session entitled Working With Young New Parents and Their Babies highlighted the special needs of these young families and ways of addressing these needs.

Ms. Norma Slover, Family Service Director at the Salem, Oregon CFRP, introduced the presenters, all of whom direct or work in programs that serve the adolescent parent population. Giving an overview of the young parent in today's world, she said she viewed the adolescent's principal problem as one of identity vs. role confusion, as defined by Dr. Erik Erikson.

"Erik Erikson describes adolescence as the fifth developmental stage. Assuming that the individual has been able to work through each of the prior four phases when he or she becomes adolescent the task then is to clarify his/her identity. This is a time when an adolescent can break dependency ties in order to plant his/her own feet firmly on the ground as an autonomous being--in essence, to prove to himself/herself that he/she can take care of himself/herself. He/she is then ready to move into a relationship based on being able to see someone else's needs objectively rather than a diffusion of her/his own mirrored needs. In our culture, this might better happen at age 24 or 25," said Ms. Slover.

Noting that for many young parents, having children isolates them from their peer group, Ms. Slover said that one reason why programs for young parents are so important is that such programs can offer them peer group support.

She continued, "In speaking with several of our young moms, they talked about feeling dislocated after pregnancy and birth. They didn't feel that they fit into any group. They missed going to dances with friends; friends didn't always want to include them; they were ashamed of losing their figures. It is a developmental assault to have a responsibility thrust on you beyond what you are ready to handle. Erikson calls these circumstances 'age inappropriate'."

Despite these enormous and trying difficulties, Ms. Slover cited several reasons why a young person might become involved in such a situation: (1) it represents a means of getting away from the family; (2) it gives a teenage girl something all of her own to love her; (3) a baby provides the adolescent with identity (as a mother) when going through an identity crisis; (4) it represents a means of rebelling against parents who say, "Don't get pregnant;" (5) it fulfills the prophecy, "they don't trust me --- they think I'll get pregnant --- I might as well;" (6) it involves a way to stay close to a strong mother.

Describing the program for young parents at the Salem CFRP, Ms. Slover noted that young parents tend to be less depressed because they have not yet had any negative experiences of parenting. She commented that they seem to make a resolution that they will be different from their parents, but soon they find themselves repeating their parents' patterns.

"Young parents tend to be more idealistic about parenting, and seem to think they have the Gerber baby. Also, some young parents seem to be more willing to say they don't have all the answers, while others, not in touch with the responsibility, think it will be just wonderful. Many young fathers tend to be irresponsible about having children, and in such cases the wife becomes a parent to both the father and child," Ms. Slover said.

Next, Ms. Zoe Smith, Community Research Specialist, Bismarck, North Dakota CFRP, told the group how she got into the field. As a past counselor in the prison system, she made a survey of men who had a long history of delinquency. Asking the question, "What could the community have done to make your life better?", she discovered that the men invariably answered that their family backgrounds included experiences of unloving relationships and that the neglect, poverty, brutality, desertion, and illegitimacy which they endured within the walls of their own homes started them down the path they followed.

"Getting to know these prisoners convinced me of the one thing that should be every child's birthright---good early parenting," she said.

She then described the TWIGS (Toddlers With Infants Gaining Stimulation) program at Bismarck, emphasizing the total involvement of the parents in the development of their very young children.

"One of my major concerns when we began looking at young parents in New Haven," said Ms. Barbara Providence, Coordinator, New Haven, Connecticut CFRP, "was how to deliver child development services to parents without direct lectures, textbooks, etc. I wanted to make sure they wouldn't miss out on what I missed out on to help them raise their children."

A former Head Start parent who has six children herself, Ms. Providence described her early years of parenting and shared some personal experiences that have led her to be very sensitive to young parents' needs in the New Haven CFRP. In her view, two major goals for these young parents are to help them gain confidence to want to take on the role of parent and to help them realize the pleasure of being a parent. The New Haven program is set up so that there is an integration of varying ages in the center, with the older parents nurturing the younger ones.

"We make it our goal to build their self-confidence as parents and adults," Ms. Providence said.

Ms. Bernice Weissbourd, President of Family Focus, Inc., Evanston, Illinois, spoke of the general depression among young parents, and commented that society seems to feel that being a parent is an unimportant role.

"Children are basically feeling what you're feeling as parents; thus, it's important for the parent to feel good about himself/herself as a person in the role of a parent," she said.

According to Ms. Weissbourd, Family Focus adopts the premise that everyone wants to be a good parent, and the staff tells the parents, "We feel you are important." The program intervenes to: (1) help parents as people, (2) help parents as parents, (3) help parents understand basic child care, and (4) impact on the interaction between parents and their child(ren).

Ms. Weissbourd noted that parent groups help parents expand their role into an advocacy role, and she emphasized that Family Focus is a "drop-in" center, rather than a "drop-off" center.

Ms. Ann Cole from Parents as Resources (PAR), in Northfield, Illinois, spoke of her program's work with parents who do not have access to preschool programs. According to Ms. Cole, PAR moved out of the school setting and into pediatric and maternal outpatient clinics in the inner city. Informal workshops (in addition to books, films, and "recipes for fun") gave parents basic guidelines as well as opportunities for socializing. She called this an unstructured approach to teaching children, in which waiting rooms become interest centers where parents and children do and make things together.

Ms. Cole admitted that there are difficulties, of course; e.g., it's an "in and out" situation and often the encounter lasts only 10 minutes. She remarked that it is essential to have the complete support of the medical staff, and to convince them that the program is an extension of their work with the family in the hospital.

Dr. Allana Elovson told participants that there are 48 families in the San Diego, California Home Start program she directs. One-half of those families are single-parent families, 13 of which are very young parents. Through her work in women's study programs, Dr. Elovson said she has seen that these young women have very special needs.

"We wanted them to understand and learn to fulfill their needs as well as their children's," she said. "These young women need a different form of delivery of services because they have fewer coping skills than young women of their age without babies."

Dr. Elovson noted that a special kind of training is necessary for anyone working with these young parents. Role playing and films on adolescence are among the many forms of training used for sensitizing staff to the unique needs of these young parents.

"These young girls are feeling ambivalence in their role and identity confusion, and they turn their anger inward and become depressed. Of course this ambivalence interferes with their relationship with their child," she said. "Furthermore, in San Diego there are great numbers of mixed families and mothers may have several babies of different ethnic/racial origins."

One of the training methods that Dr. Elovson uses in the San Diego program is for staff to list all the reasons why a mother may have trouble relating to her child and to be sensitive to these.

"These young mothers want eternal verities. They want to know not how each child is different, but how each is similar. They need to know the constants," she emphasized.

One of the ways San Diego staff members open up communication with these young girls is through the technique of ventriloquizing---that is, giving the girl "permission" to vent feelings of anger, guilt, etc. to friends, family, and boy friends through the medium of the staff person.

"We're concerned with the lives of these adolescent girls as much as we are with the lives of the children; so in our work we direct our attention to the mother's future as we do to the child's, as we work with her to improve her mothering relationship," Dr. Elovson concluded.

Ms. Ruth MacDonald, Curriculum Coordinator of the Exploring Childhood Program, Education Development Center, Newton, Massachusetts, stated that the major thrust of the Exploring Childhood materials is to help young parents learn something about the responsibility of child raising.

"A reduced self-image is so much a part of these young girls' lives," she said, "for they have no models to follow."

In her work with young parents, Ms. MacDonald tells them, "A baby is going to take a lot more from you than it's going to give you," a fact which both Ms. Slover and Dr. Elovson had alluded to earlier in their presentations.

Ms. MacDonald told participants that Raising a Family Alone is a book developed at EDC which deals with coping mechanisms for single parents.

Its main message, and one which Ms. MacDonald emphasized in her presentation, is to tell a single parent, "You are a family and you can think of yourself in a positive, legitimate way." Raising a Family Alone contains a variety of information to help cope with the financial strains of divorce and suggests resources for single parents.

Other EDC materials which Ms. MacDonald described include "Babies Are Beginnings," which provides basic child care information on weekly cards. Sensitive to the young parents, the cards were prepared to provide young parents with some simple, understandable tips in "learning to know about your baby."

Other materials available from EDC are (1) "Under Stress--Keeping Children Safe," which deals with child abuse and helps parents to understand and control their stress so that they don't abuse their children; and (2) "Fear, Anger, Dependence," which explores different coping mechanisms. All of these materials are useful in all kinds of settings, Ms. MacDonald said.

She concluded by saying, "We have created a myth of independence in our society that has 'done a number' on a lot of young parents."

All of the presenters addressed that myth and the ways in which they are intervening with these young parents to attempt to make their lives and the lives of their children healthier and happier.

STEVENSON TELLS PARTICIPANTS WAYS TO HELP SINGLE PARENTS AND THEIR CHILDREN

Ms. Fannie Smith, Project Developmental Continuity Coordinator, Lister Elementary School, Tacoma, Washington, chaired a session on Involving Single Parents in the Education of Their Children.

After introductory remarks in which Ms. Smith emphasized the importance of parent involvement in early childhood education programs, Ms. Jane Stevenson, Coordinator of Services for Singles, Johnson County Mental Health Center, Mission, Kansas, told participants about the program and special classes for singles which had been successful in her area.

Although she acknowledged that her work had been mainly with divorced parents, Ms. Stevenson commented that basically all single parents---divorced, widowed, or unwed---have many of the same kinds of needs and need similar help, especially in the emotional area.

Ms. Stevenson told participants that her program tries to help single parents deal with their own feelings first, so that they can then better understand the feelings of their children. She noted that one of the first steps in doing this is to get the parents together to discuss how their situations are different---e.g., how certain feelings about singleness may differ, depending upon whether the person is divorced, widowed, or never married. The next step is for parents to look for common points; they then begin to see that they all are experiencing some of the same feelings such as loneliness, anger, fear, etc.

Ms. Stevenson remarked that preschoolers often undergo behavior changes as a result of the stress of death or divorce of a parent(s). Among others, she listed the following: regression in toilet training; increased instability; whining; crying; general fearfulness; acute separation anxieties; sleeping problems; confusion; aggressive behavior or fear of aggressive behavior; tantrums; increasing possessiveness (caused by the fear of losing something else); working extra hard at "being good" or pleasing the remaining parent; need for relationships; quick outreach to adults; and need for physical contact.

"To help children cope with having only one parent, there is a great need for consistency," Ms. Stevenson said, "thus disruption of the child's routine should be avoided if at all possible. The child also needs a lot of reassurance that he/she is still cared about and that, despite the fact that one parent has left, the situation will remain relatively stable. At this time there is also a great need for the child to express his/her feelings, either verbally or physically."

Ms. Stevenson said that teachers should be aware of the above-mentioned behavior changes and perhaps help the children to verbalize or act out their anger or other feelings on the subject. She noted that children often blame themselves for the loss of a parent and that teachers can help explain that it was not the children's fault.

In helping parents, Ms. Stevenson said her program attempts to meet the physical needs (such as housing and food) of the parents first by referring them to appropriate resource agencies. Then the emotional aspect of being single is dealt with, generally by arranging for single parents to meet and help each other, through discussions and sharing of experiences.

Next, Ms. Stevenson said the parents are asked to list all the positive aspects of being single parents so that they can start to feel better about themselves. Then the program asks the parents to explain as much of the situation as possible to their children. (She cautioned that this may take more than one explanation because children are often unable to understand divorce or death, or because they don't want to hear about it.)

Another part of Ms. Stevenson's program deals with helping parents to build a new life after they have accepted what has happened. This includes learning to break some of the old ties, dating, setting rules, and helping children to solve their own problems.

"Many sharing groups have also been started for single parents," she said. "Although some of these groups do not meet on a structured basis, they allow single parents the all-important opportunity to communicate with other people in their situation."

Ms. Stevenson concluded her presentation by listing some things which teachers and educators involved with single parents can do to help---i.e., coordination of resources such as job counseling, financial assistance, legal aid, etc.; enlisting the help of the community, e.g., clergymen, mental health centers, and other agencies; and developing local resources.

She noted that the Johnson County Mental Health Center offers a variety of mental health education courses for single parents, including New Beginnings for Singles, New Horizons for Singles, Survival Skills for Single Parents, and various support groups.

HILLIARD AND RAMIREZ HIGHLIGHT ISSUES IN INDIVIDUALIZING PROGRAMS FOR PARENTS AND CHILDREN

Dr. Asa G. Hilliard, Dean of the School of Education at San Francisco State University, San Francisco, California, began a discussion regarding Issues in Individualizing Programs for Parents and Children by citing some of his concerns in the area of individualized education.

Noting that most of the information and guidelines in the field of education seem to originate in the courts and legislatures, rather than with clinical observations in the field, Dr. Hilliard said, "I am against individualized education as I've heard it discussed but am for it in a more human sense."

He added that there is a failure on the part of some policymakers to take into account people's past and present circumstances.

"If a global perspective were considered, people could see that many of the so-called deficiencies that they think exist for a certain culture do not exist in the same sort of culture elsewhere," he said.

"What most people mean by individualized instruction is to send the children through the same institution in single file. This is dehumanizing," he added.

Dr. Hilliard said that he rejects the "diagnosis and prescription" model of individualizing for children mainly because the model assumes that there is something wrong, when in fact there is nothing wrong with 99 percent of the children in the program. He also said it is unfair to assume (as this model does) that there is a standard learning sequence for all children, when in fact all children take a variety of paths to achieve their learning.

"This model also assumes that we agree on the outcomes of learning, which we don't," he said. "Prematurely assuming more than we know could be harmful to the children. Some programs are set even before the child is in the classroom and this is backwards; you must listen to the child and find out where he/she is before you can individualize."

He added that teaching is defined by the learner, not the teacher; therefore, the best individualization is done when the teacher is concerned with noticing the child, rather than with modeling for the child.

"Any education that is not culturally based cannot be individualized," Dr. Hilliard said, adding that in order to individualize, one must look at the child as a total person, rather than as an object.

Commenting that the social setting provides the raw material for learning, Dr. Hilliard stressed that individualized learning calls for feedback from those around a child and social learning is required if a child is to succeed.

"Every time you talk with a child, allow him/her to use his/her language. This helps build confidence, and confidence is perhaps the most important aspect of learning. Through confidence one can reaffirm what the child has been doing and what the child can become," he concluded.

The next speaker was Dr. Judith Ramirez, Assistant Professor, Department of Teacher Education, California State University, Sacramento, California. She explained that when the concept of individualized learning first originated, there was no problem since most people felt that it would be used with older children in grade school and high school. However, problems arose with traditional values when individualization was first implemented at the early childhood level.

Specifically, she stated that it has always been the belief of early childhood teachers that most of children's learning occurs in socializing with other children, whereas individualized instruction would tend to isolate many youngsters.

She added that many programs call for subject-oriented material, while it has long been held by early childhood educators that the child learns best by the "whole" concept.

Dr. Ramirez also expressed disapproval of the diagnosis-and-prescription model because it tends to focus on the problems and disabilities of the child, rather than on the strengths of the child and the teacher's role in eliciting and guiding the child's abilities to achieve something.

She stated that if an individualization program does not increase a child's ability to solve problems, then the program should not be used.

She said that a systematic method of assessment and recordkeeping is essential for an individualization program to work, but if that process tends to overwhelm the teacher to the point that instruction is neglected, then it should be abandoned or at least reassessed.

CONFEREES DISCUSS ISSUES IN INTEGRATING DEMONSTRATION PROGRAMS INTO ONGOING SYSTEMS

"Millions of dollars are allocated to demonstration programs," began Mr. Phil Silvers, Project Director, Pacific Consultants, Inc., Washington, D.C. "When the Federal funding is gone, some communities have successfully transferred the support of the demonstration project to local resources. With others, once the funding is removed, every trace of the demonstration program vanishes."

Differentiating between implementation (the process or condition in which the components of a demonstration program are effectively in place and operating according to the guidelines of the demonstration) and internalization (the situation in which a local ongoing system has "ownership" of the demonstration program and will continue its operation even without Federal funding), Mr. Silvers noted that in the course of these processes some diffusion of program (or component) values or approaches may take place. (For example, demonstration program staff may be asked to tell other agencies about their approaches.) He commented that this session would not deal with such dissemination and replication, but would focus on internalization.

Mr. Silvers gave the following as some of the indications that "internalizing" is taking place: a new custom develops, school/agency procedures are enacted, regulations are made, policies are formulated, and staff positions are established.

Next, Mr. Jerry Lapides, Director of Mental Health Services, Head Start Bureau, Administration for Children, Youth and Families (formerly Office of Child Development), Washington, D.C., spoke about factors which inhibit demonstration projects. He raised questions such as (1) does the community understand why a demonstration project is coming? (2) did the community ask for it? (3) do community members understand the project's concept? (4) does the project fill a community need? (5) what is the project's planning, timing, and funding like? (6) what support (or lack thereof) does the project receive from "top management" for continuation? and (7) what provisions for data collection and analysis have been made?

Mr. Lapides noted that there is a built-in value conflict between a demonstration project and an ongoing local project because local personnel realize the demonstration project is different. He cited feelings and attitudes as part of inhibiting factors---e.g., commitment to the status quo and resistance to change, a feeling that ideas will not be accepted, and distrust of a new demonstration project.

Dr. Jerry Jonnson, Adjunct Associate Professor, University of Nevada, Reno, Nevada, next enumerated some of the characteristics that should enhance a demonstration project's potential to internalize successfully:

1. In the beginning, during the period of local planning and search for local support, the project should be viewed as a "problem-solving" project (helping to meet local needs), rather than an "opportunistic" one (offering a chance to procure external funding).

2. During project implementation, "mutual adaptation" should exist whereby all parties involved modify their formal and informal organizational relationships.

3. There should be joint accountability which advocates a sustained union of all parties for the project's duration.

4. The project should be comprehensive, so that it focuses on many components and different delivery systems for these components, and pervasive, so that it reaches children, parents, staff, and community members.

5. A stable, free-flowing communications network should exist which enhances interaction among all parties involved.

6. Strategies should be implemented that allow for and support the following:

    a. Ongoing planning and program redesign to meet changing needs.

    b. Staff training based on practical issues rather than theoretical concepts.

c. Local development of materials rather than reliance on outside resources.

d. Development of a "critical mass" of personnel who advocate the project.

c. Consonance between the values and goals of the project and those of the parents, local and regional staff, and communities.

7. There should be active parent involvement in the home, school, and community which is directed toward project goals.

8. The project should be perceived by regional or district-level officials as affordable, successful, politically acceptable, and important to regional or district priorities before the decision is made to continue the project.

Dr. Jonnson noted in conclusion that demonstration projects that are successfully internalized have central definition and direction, coordination, local agency and community support, and an absence of rivalry or conflict.

Following these remarks, some case histories of internalization were provided by other panelists.

FAMILY ACTION PLAN SEEN AS CORE OF CFRP

In a session entitled the Child and Family Resource Program: Developing a Family Action Plan, Ms. Marca Piehuta, Assistant Project Manager, Dingle Associates, Inc., Washington, D.C., described the Child and Family Resource Program (CFRP), a Head Start demonstration program for families with children from the prenatal stage through age eight, and led a discussion of CFRP representatives on how individual and family assessment helps families identify their strengths in order to meet their needs.

Following a sound/slide presentation on CFRP, presenters discussed various processes and approaches to developing a family action plan for identifying and meeting individual and family needs.

Ms. Malden Riley, Senior Family Advocate, New Haven, Connecticut CFRP, stressed the importance of developing trust among staff members. She noted that when they were first hired, all New Haven CFRP family advocates attended a 2-week training session, spent several mornings walking through the target community to familiarize themselves with it, and developed forms to use in the assessment process which would provide sufficient information but not duplicate existing information about enrolled families. She commented that all forms were tried out in role playing sessions with five family advocates, the secretary, and the program coordinator.

Ms. Riley said that in New Haven, after the first contact with the family, the family advocate meets with the family, goes over the CFRP fact sheet, obtains the family's verbal commitment to the program, and emphasizes that all information about the family will be treated confidentially by the family advocate and CFRP staff. At the second meeting with the family, the family advocate introduces the family profile form, the family assessment form, and the individual assessment form. Completion of these forms represents the beginning of the assessment process, which may take three to four meetings to complete.

Next, Ms. Juanita Robinson, Home Visitor, St. Petersburg, Florida CFRP, noted that information on assessment forms is compiled to assist assessment team members in obtaining a picture of the family.

"The home visitor in a sense 'negotiates' with the family and helps family members prioritize goals and break goals down into objectives," she said. "Families are reassessed at 6-month intervals, and we always strive to build on the strengths of clients," she added.

Ms. Georgene Graser, CFRP Parent from Pottsville, Pennsylvania, commented that when her family entered the program, the home visitor made several visits and interviewed the entire family. The CFRP staff then discussed the family's strengths and needs with the assessment committee and the advisory board.

"The staff presented me with a lot of options and I made choices for my children based on these options," she said.

Ms. Ruth Vance, Social Services Coordinator, Gering Nebraska CFRP, discussed the Life Support Systems---a system developed by Dr. George Witt (New Haven, Connecticut) and used by the Gering CFRP.

"Each home visitor fills out a form describing how each family's life support systems are met," Ms. Vance said. "During the family's team assessment process, ways can also be discussed to change skills in family support activities and an action plan is designed."

Ms. Bette Hendrickson, Social Services Coordinator, Bismarck, North Dakota CFRP, emphasized that after program staff members assess family needs, the Bismarck CFRP staff ensures that where there are unmet needs, solutions to these needs are sought.

Ms. Hendrickson noted that the overall BECEP (Bismarck Early Childhood Education Program), of which CFRP is a significant part, includes various programs for health/nutrition, child development, child management, and social services.

Ms. Melba Burkhalter, Assessment Coordinator, Oklahoma City, Oklahoma CFRP, explained that before a formal assessment meeting, it is important to collect data on all individual families so that at the time of the assessment meeting a family profile is available based on these data.

"The purpose of the assessment team meeting is to assist families in identifying strengths and needs and determining how to meet their goals," Ms. Burkhalter said. "We try to do with, not for, families."

She noted that when a family is not present, the family is represented in team assessment by the family advocate. When a family does participate in the meeting, only the people whom the family has met and feels comfortable with attend the assessment.

Ms. Burkhalter stressed the advantages of the team approach as being that (1) the team members work together using expertise from specific disciplines such as health, social services, etc., and (2) it provides a model or example for an approach to problem solving.

Ms. Ruth Larson, Family Advocate, Salem, Oregon CFRP emphasized the importance of continual reassessment and updating of the family action plan.

"Reassessment has several purposes. It shows (1) the idea of process, showing how CFRP helps with goal achievement; (2) patterns regarding coping with life situations and meeting needs; (3) strengths regarding what families need now versus what they can provide for themselves; and (4) reinforcement when families do accomplish things," she said.

Ms. Larson stressed that reassessment also provides families with good learning experiences.

In the question-and-answer period following these remarks, staff members commented that although there are individual differences at each CFRP, all CFRPs must adhere to basic guidelines developed by the Administration for Children, Youth and Families. For example, some programs (such as Salem, Oregon) use written agreements with their families, while others obtain verbal commitments from families. Presenters noted other differences between CFRPs, too; such as: kinds and amounts of staff training, kinds and amounts of family involvement, and kinds and amounts of local resources available to help families so that they can meet their own needs.

In summary, Ms. Piehuta commented,"CFRP provides a basic foundation or family support, and an individual assessment of each family member---both of which contribute to child and family development, resource and skill building."

ITC STAFF DESCRIBE DEVELOPMENTAL ASSESSMENT

A session entitled Responding to Individual Needs: The First Step-Assessment dealt with some suggested procedures for the assessment of preschool children, based on an extensive review of the "state-of-the-art."

Mr. Michael Annison, Project Director, International Training Consultants (ITC), Denver, Colorado, began by describing the organization's contract with the Administration for Children, Youth and Families (formerly Office of Child Development), to conduct a study of assessment procedures utilized by Head Start programs to respond to individual needs.

He explained that questions being studied include: What is developmental assessment? What instruments are in use? What characteristics help Head Start Centers develop good individualized programs? And, how can assessments be used to help individualized instruction?

Commenting that the term assessment has been used in various ways in Head Start, he focused on the assessment of the individual child in an individual program and highlighted three areas: (1) the process of assessing the child (problems, effectiveness, etc.); (2) the difference between assessment theory and practice---e.g., some instruments may take too much time to be usable in the classroom; and (3) the provision of suggestions which will be made in March 1978 as to how ACYF can help programs improve assessment techniques in the classroom.

He related that ITC responsibilities include:

1. Carrying out a field study to determine actual assessment practices. (This includes questionnaires for directors and teachers and a limited number of site visits to be conducted in the fall of 1977.)

2. Reviewing the literature on developmental assessment.

3. Reviewing instruments presently in use and compiling a list of the most commonly used instruments.

4. Continuing work with practitioners and theoreticians to define information so that it is useful to ACYF programs.

Next, Ms. Arna Caplan, Senior Research Associate, International Training Consultants, Denver, suggested that developmental assessment be defined as a way of describing a child's place in the sequence of development and the process of learning, so that instructional programs can be planned and implemented to foster continued development. This is based on the premise that developmental assessment is different, important, and useful to programs.

According to ITC staff, developmental assessment is (1) child-centered, (2) classroom-centered, and (3) multi-dimensional (in that there are many ways of looking at a child sensitively).

Ms. Caplan noted that developmental assessment should be viewed as a process, not just as techniques or procedures, and should involve:

1. Determining program goals.
2. Selecting the best way to gather needed information regarding the child's status or level of functioning in relation to the program.
3. Using the information that has been gathered to plan the program.
4. Reassessing to check the child's progress in the program.
5. Planning again.

Noting that no one test or procedure can be applied to all children and situations, Ms. Caplan suggested that tests and formal instruments be used in conjunction with systematic observation (checklists, anecdotal records, observation of growth over time, etc.), parent interviews (to track developmental levels and daily progress), and samples of the child's work.

"Emphasize what the child can do," she said. "Preschool teachers have unique qualities of warmth, sensibility, and caring. Coupled with objectivity and the general ability to integrate and analyze information, these kinds of qualities enable us to do a good job of assessing children."

Next, Ms. Oralie McAfee, Assistant Project Manager, International Training Consultants, Denver, offered a few words of caution regarding developmental assessment. She began by reminding participants that the assessment process and assessment instruments provide a lot of information on a child and that in some instances, more data on a child may be available than can possibly be used; thus she stressed the importance of assessing available information and using it judiciously.

She added, "Remember that the tools at hand for assessment instruments and procedures are still very crude, and some children simply may not be interested in performing."

She also cautioned that many suggested procedures assume that some information is available when it actually is not, and thus it is important to look at a child in his/her total setting.

"We have some hunches as to how to design and implement a plan, but we are just now getting the data in and are not ready to make recommendations," she said. "It's our general feeling that a variety of methods must be used. Parent reports, staff observation and interviews, and child products all tell what a child can do."

Ms. McAfee commented that developmental assessment must be done early in the year to help in program planning, and stressed that it requires ongoing planning and periodic updating of information for each child.

"Skillful management of classroom time is needed so that this information can be gathered for every child," she concluded.

LIST OF PRESENTERS MENTIONED IN THIS REPORT

ALI, Ms. Yvonne - EPSDT Project Director, National Child Day Care Association, 1200 North Capitol Street, N.W., Washington, D.C. 20002, (202) 638-3317

ANDREWS, Ms. Bernice - Training Coordinator, Home Start Training Center, West Central West Virginia Community Action Association, Inc., 804 Ann Street, P.O. Box 227, Parkersburg, West Virginia 26101, (304) 485-4455

ANNISON, Mr. Michael, Project Director, International Training Consultants, 838 Grant Street, Denver, Colorado 80203, (303) 832-2102

ARENAS, Ms. Soledad - Education Specialist, Head Start Bureau, Administration for Children, Youth, and Families, Office of Human Development Services, Department of Health, Education, and Welfare, P.O. Box 1182, Washington, D.C. 20013, (202) 7[illegible]5-7795

ARONSON, Dr. Susan - Assistant Professor, Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, Pennsylvania 19129, (215) 842-6000

BEATY, Ms. LaVerne - Home Visitor, Arkansas River Valley Area Council, Inc., (ARVAC), Home-Based Training, Arkansas Polytechnic College, P.O. Box 1358, Russellville, Arkansas 72801, (501) 968-6493

BLACK, Ms. Diane - Mental Health Consultant, 306 Lee Street, Apt. #105, Oakland, California 94611, (Phone number not available)

BOSWELL, Dr. Arnita - Associate Field Work Professor, University of Chicago, School of Social Service Administration, Chicago, Illinois 60637, (312) 753-4653

BRADDY, Ms. JoAnn - Head Start/Home-Based Training Director, Arkansas River Valley Area Council, Inc. (ARVAC), Home-Based Training, Arkansas Polytechnic College, P.O. Box 1358, Russellville, Arkansas 72801, (501) 968-6493

BRADLEY, Ms. Susan - Home-Based Coordinator, Home Start Training Center, West Central West Virginia Community Action Association, Inc., 804 Ann Street, P.O. Box 227, Parkersburg, West Virginia 26101, (304) 485-4455

BRIGHT, Ms. Hazel - Home Visitor, Clinch-Powell Educational Cooperative, P.O. Box 233, Tazewell, Tennessee 37879, (615) 869-3605

BROWN, Ms. Dorothy - Community Resources Coordinator, Child and Family Resource Program, Nebraska Panhandle CAA, 1840 Seventh, P.O. Box 340, Gering, Nebraska 69341, (308) 436-5076

BRUCE, Dr. Kellene - Project Director, Roy Littlejohn Associates, Inc., 1328 New York Avenue, N.W., Washington, D.C. 20201, (202) 638-1388

BUCKLEY, Ms. Jennifer - Parent, Wichita Child Day Care Association, Suite 804, Century Plaza, 111 West Douglas, Wichita, Kansas 67202, (316) 265-0871

BURKHALTER, Ms. Melba - Assessment Coordinator, Child and Family Resource Program, 12500 Northeast 42nd, Spencer, Oklahoma 73084, (405) 769-3355

CAPLAN, Ms. Arna - Senior Staff Member, International Training Consultants, 838 Grant Street, Denver, Colorado 80203, (303) 832-2102

CARTER, Ms. Sylvia - Parent Coordinator, Head Start Regional Resource Training Center, University of Maryland, 4321 Hartwick Road, Room L-220, College Park, Maryland 20740, (301) 454-0100

CHISOM, Ms. Floretta - Director, Oakland Head Start, 659 14th Street, Oakland, California 94612, (415) 839-2000

COCHRAN, Ms. Deborah - Trainer, Home Start Training Center, 2822 North 5th Street, Milwaukee, Wisconsin 53212, (414) 562-8600

COLE, Ms. Ann - Consultant, Parents As Resources, 464 Central Avenue, Northfield, Illinois 60093, (312) 441-5617

COOPER, Ms. Judy - Director, Child and Family Resource Program, Mid-Willamette Valley Community Action Agency, Inc., 2455 Franzen Street, N.E., Salem, Oregon 97301, (503) 581-1152

DAVIS, Ms. Jo - Home Visitor, Home Start Training Center, Bear River Community Action Agency, 67 South Main Street, Millville, Utah 84326, (801) 753-0951

DEAN, Ms. Vicki - Training Coordinator, Clinch-Powell Educational Cooperative, Home Start Training Center, P.O. Box 233, Tazewell, Tennessee 37879, (615) 869-3605

deBOLT, Ms. Carolyn - Home Visitor, Home Start Training Center, Bear River Community Action Agency, 67 South Main Street, Millville, Utah 84326, (801) 753-0951

DELORIA, Mr. Dennis - Chief, Evaluation Branch, Research and Evaluation Division, Administration for Children, Youth and Families, Office of Human Development Services, Department of Health, Education, and Welfare, P.O. Box 1182, Washington, D.C. 20013, (202) 755-7750

DINGLE, Ms. Marcy - President, Dingle Associates, Inc., 525 School Street, S.W., Suite 301, Washington, D.C. 20024, (202) 554-5532

ELOVSON, Dr. Allana - Director, Home Start Program, 4644 Idaho Street, San Diego, California 92116, (714) 755-3850

ENERSON, Mr. Lowell - Director, Oklee Head Start, Inter-County Community Council, Inc., P.O. Box 187, Oklee, Minnesota 56742, (218) 796-2325

EVANS, Mr. Steve - Assistant Training Coordinator, Rono Adult Focus Training Center, P.O. Box 10167, Reno, Nevada 89510, (702) 972-1601

GAGE, Dr. Jimmy A. - Principal, Richmond School, 466 Richmond, S.E., Salem, Oregon 97301, (503) 399-3180

GAINES, Dr. Rosslyn - Associate Professor, Department of Psychiatry and Psychology, 760 Westwood Plaza, NPI - Room C8-698, UCLA, Los Angeles, California 90024, (213) 825-0518

GIBSON, Ms. Frankie - Parent Coordinator, Wichita Child Day Care Association, Suite 804, Century Plaza, 111 West Douglas, Wichita, Kansas 67202, (316) 265-0871

GOETZ, Ms. Elizabeth - Education Coordinator, Wichita Child Day Care Association, Suite 804, Century Plaza, 111 West Douglas, Wichita, Kansas 67202, (316) 265-0871

GRASER, Ms. Georgene - Parent, Schuylkill County Child Development Program, Box 302, Route 61, Schuylkill Haven, Pennsylvania 17972, (717) 385-3986

HAIMAN, Dr. Peter - Project Director, Development Associates, Inc., 693 Sutter Street, San Francisco, California 94102, (415) 776-0120

HENDRICKSON, Ms. Bette - Social Services Coordinator, Child and Family Resource Program, Bismarck Public School District #1, 400 Avenue E., Bismarck, North Dakota 58501, (701) 255-3866

HEWETT, Ms. Kathy - Consultant, Abt Associates, Inc., 55 Wheeler Street, Cambridge, Massachusetts 02138, (617)492-7100

HILLIARD III, Dr. Asa G. - Dean of the School of Education, San Francisco State University, 1600 Holloway, San Francisco, California 94132, (415) 469-2051

HODGES, Dr. Walter - Director, Follow Through, Georgia State University, University Plaza, Atlanta, Georgia 30303, (404) 658-2584

JOHNSON, Ms. Charlene - Home Visitor, Home Start Training Center, 2822 North 5th Street, Milwaukee, Wisconsin 53212, (414) 562-8600

JOHNSON, Mr. Richard H. - Social Service and Parent Involvement Senior Specialist, Head Start Bureau, Administration for Children, Youth, and Families, Office of Human Development Services, P.O. Box 1182, Washington, D.C. 20013, (202) 755-7700

JOHNSON, Mr. Shelby - Director, Parent Education Demonstration Project, 795 Peachtree Street, SAC Suite 500, Atlanta, Georgia 30308 (404) 875-8011

JOHNSON, Dr. Jerry C. - Adjunct Associate Professor, University of
Nevada, Reno, Nevada
(Home) 91 McKay, Reno, Nevada 89509, (702) 826-5842

KOPP, Ms. Nelda - Handicapped Specialist, Reno Adult Focus Training
Center, Community Services Agency of Washoe County, P.O. Box 10167,
Reno, Nevada 89510, (702) 972-1601

KRESS, Ms. Kathy - Co-Director, Home Start Training Center, 2822 North
5th Street, Milwaukee, Wisconsin 53212, (414) 562-8600

LAPIDES, Mr. Jerry - Director of Mental Health Services, Head Start
Bureau, Administration for Children, Youth, and Families, Office
of Human Development Services, Department of Health, Education,
and Welfare, P.O. Box 1182, Washington, D.C. 20013,
(202) 755-7768

LARSON, Ms. Ruth - Family Advocate, Child and Family Resource Program,
2455 Franzen Street, N.E., Salem, Oregon 97301, (503) 581-1152

LEGGINS, Ms. Bette - Parent, Wichita Child Day Care Association,
Suite 804, Century Plaza, 111 West Douglas, Wichita, Kansas 67202,
(316) 265-0871

LONG, Ms. Marilyn - Training Coordinator, Home Start Training Center,
Bear River Community Action Agency, 67 South Main Street,
Millville, Utah 84326, (801) 753-0951

LOVE, Dr. John - Project Director, High/Scope Educational Research
Foundation, 600 North River Street, Ypsilanti, Michigan 48197,
(313) 485-2000

MacDONALD, Ms. Ruth - Curriculum Coordinator, Exploring Childhood
Program, Educational Development Center, 55 Chapel Street,
Newton, Massachusetts 02160, (617) 969-7100

MAGINNIS, Ms. Berdine - CDA Specialist, Community Development Institute,
1615 California Street, Room 206, Denver, Colorado 80202,
(303) 534-3517

McAFEE, Ms. Oralie - Assistant Project Director, International Training
Consultants, 838 Grant Street, Denver, Colorado 80203,
(303) 832-2102

McINTOSH, Ms. Betty - Director, Snohomish County Head Start, P.O. Box 1185, Everett, Washington 98206, (206) 252-5141

McLEAN, Ms. Rhonda - Parent Coordinator, Learning Institute of North Carolina, 1001 Elm Street, Greensboro, North Carolina 27401, (919) 688-8211

MEDRANO, Mr. Robert - Director, Bilingual-Bicultural CDA Program, Texas A&I University, Kingsville, Texas 78363, (512) 595-2731

MIHATA, Ms. Peggy Jo - Director, Clackamas County Head Start, Davignon Hall, Room 319, Maryl Hurst Campus, Maryl Hurst, Oregon 97036, (503) 635-4782

MORCUM, Mr. Mike - Trainer, Reno Adult Focus Training Center, P.O. Box 10167, Reno, Nevada 89510, (702) 972-1601

MURRAY, Ms. Evelyn - Director, Perceptual-Psychomotor Program, Bristol, Virginia Schools, 222 Oak Street, Bristol, Virginia 24201, (703) 669-8181

NAUTA, Ms. Marritt - Consultant, Abt Associates, Inc., 55 Wheeler Street, Cambridge, Massachusetts 02138, (617) 492-7100

NOBLE, Ms. Sheri - Director, Home Start Training Center, Bear River Community Action Agency, 67 South Main Street, Millville, Utah 84326, (801) 753-0951

O'CONNOR, Ms. Mary - Head Start Project Manager, Community Health Foundation, 2727 West Girard Avenue, Evanston, Illinois 60201, (312) 492-4661

O'KEEFE, Dr. Ann - Director, Home Start Training Centers/Child and Family Resource Program, Administration for Children, Youth, and Families, Office of Human Development Services, Department of Health, Education, and Welfare, P.O. Box 1182, Washington, D.C. 20013, (202) 755-7700

PAIGE, Ms. Clara - Director, Norfolk Head Start, STOP Organization, 415 St. Paul Boulevard, P.O. Box 1078, Norfolk, Virginia 23501, (804) 627-3541

PERSYN, Ms. Gloria - Parent, Wichita Child Day Care Association, Suite 804, Century Plaza, 111 West Douglas, Wichita, Kansas 67202, (316) 265-0871

PETERS, Mr. Jack - Program Operations Manager/Director, Reno Adult Focus Training Center, Community Services Agency of Washoe County, P.O. Box 10167, Reno, Nevada 89510, (702) 972-1601

PHELAN, Mr. Paul - Head Start State EPSDT Coordinator, 630 Rockland Street, Lahcaster, Pennsylvania 17602, (717) 299-7301

PHILLIPS, Dr. Margaret - Nutrition Specialist, Head Start Bureau, Administration for Children, Youth and Families, Office of Human Development Services, Department of Health, Education, and Welfare, P.O. Box 1182, Washington, D.C. 20013, (202) 755-7944

PIEHUTA, Ms. Marca - Assistant Project Manager, Dingle Associates, Inc., 525 School Street, S.W., Suite 301, Washington, D.C. 20024, (202) 554-5532

PIERSON, Dr. Donald - Director, Brookline Early Education Project, 287 Kent Street, Brookline, Massachusetts 02146, (617) 495-3544

PROVIDENCE, Ms. Barbara - Coordinator, Child and Family Resource Program, 197 Dixwell Avenue, New Haven, Connecticut 06511, (203) 787-0209

RAMIREZ, Dr. Judith - Assistant Professor, Department of Teacher Education, California State University, 6000 J Street, Sacramento, California 95819, (916) 454-6670

RANDOLPH, Dr. Linda - Director of Health Services, Head Start Bureau, Administration for Children, Youth and Families, Office of Human Development Services, Department of Health, Education, and Welfare, P.O. Box 1182, Washington, D.C. 20013, (202) 755-7944

REASONER Ms. Linda - Training Coordinator, Arkansas River Valley Area Council, Inc. (ARVAC), Home-Based Training, Arkansas Polytechnic College, P.O.Box 1358, Russellville, Arkansas 72801, (501) 968-6493

RICH, Dr. Dorothy - Director, Home-School Institute, 3301 Newark Street,
N.W., Washington, D.C. 20008, (202) 362-9066

RILEY, Ms. Malden - Senior Family Advocate, Child and Family Resource
Program, 197 Dixwell Avenue, New Haven, Connecticut 06511,
(203) 787-0209

RILEY, Dr. Mary Tom - Head Start Regional Training Officer (Region VI),
Texas Tech, P.O. Box 4170, Lubbock, Texas 79409, (806) 742-3296

ROBINSON, Ms. Juanita - Home Visitor, Child and Family Resource Program,
1344 22nd Street South, St. Petersburg, Florida 33712,
(813) 821-4627

ROGGMAN, Ms. Lauri - Home Visitor, Home Start Training Center, Bear
River Community Action Agency, 67 South Main Street, Millville,
Utah 84326, (801) 753-0951

RUCKER, Ms. Ruth - Director, Parent and Child Center, 2124 14th Street,
N.W., Washington, D.C. 20009, (202) 462-3375

RUOPP, Dr. Richard - Vice President, Abt Associates, Inc., 55 Wheeler
Street, Cambridge, Massachusetts 02138, (617) 492-7100

SANDLER, Mr. Jerrold - Executive Program Director, Parent Education
and Television Program, Applied Management Sciences, 962 Wayne
Avenue, #701, Silver Spring, Maryland 20910, (301) 585-8181

SCHAEFER, Dr. Earl - Professor, Maternal and Child Health, University
of North Carolina, Chapel Hill, North Carolina 27514,
(919) 966-2017

SCHNEIDER, Ms. Rose - Health Specialist, Arkansas River Valley Area
Council, Inc. (ARVAC), Home-Based Training, Arkansas Polytechnic
College, P.O. Box 1358, Russellville, Arkansas 72801,
(501) 968-6493

SCHWAB, Ms. Emily - Consultant, West Central West Virginia Community
Action Association, Inc., 804 Ann Street, P.O. Box 227,
Parkersburg, West Virginia 26101, (304) 485-4455

SEGUIN, Ms. Florence - Training Specialist, Children (1st) First, Inc.,
525 School Street, S.W., Suite 303, Washington, D.C. 20024,
(202) 554-9170

SHEARER, Mr. David - Co-Director, Portage Project and Home Start
Training Center, 412 East Slifer, Portage, Wisconsin 53901,
(608) 742-5342

SILVERS, Mr. Philips J. - 1312 Independence Avenue, S.W., Washington,
D.C. 20003, (202) 543-8841

SLOVER, Ms. Norma - Family Service Director, Child and Family Resource
Program, Mid-Willamette Valley Community Action Agency, Inc.,
2455 Franzen Street, N.E., Salem, Oregon 97301, (503) 581-1152

SMITH, Ms. Fannie - Project Developmental Continuity Coordinator,
Lister Elementary School, 2106 East 44th Street, Tacoma, Washington,
98405, (206) 475-5300

SMITH, Ms. Zoe - Community Research Specialist, Child and Family
Resource Program, Bismarck Public School, District #1, 400 Avenue
E, Bismarck, North Dakota 58501, (701) 255-3866

STEVENSON, Ms. Jane - Johnson County Mental Health Center, 600 Lamar
Street, Mission, Kansas 66202, (913) 384-1100

SUTTON, Dr. Arlene Vigil - Director, Bilingual-Bicultural Resource
Network, Inter-American Research Associates, 910 16th Street,
Suite 722, Denver, Colorado 80202, (303) 534-1290

TARTER, Mr. Desmon - Director, Home Start Training Center, Clinch-
Powell Educational Cooperative, P.O. Box 233, Tazewell,
Tennessee 37879, (615) 869-3605

VANCE, Ms. Ruth - Social Services Coordinator, Child and Family
Resource Program, Nebraska Panhandle CAA, 1840 Seventh, P.O. Box
340, Gering, Nebraska 69341, (308) 436-5076

VICINANZA, Dr. Paul - Child Development Specialist, Administration
for Children, Youth, and Families, Office of Human Development
Services, Department of Health, Education, and Welfare,
P.O. Box 13716, Philadelphia, Pennsylvania 19101,
(215) 596-6761

WEISSBOURD, Ms. Bernice - President, Family Focus, Inc., Miller School, 425 Dempster Street, Evanston, Illinois 60201, (312) 869-1500

WICKLUND, Dr. Goodrun - Coordinator of Curriculum, Head Start Leadership Development Program, Texas Southern University, 3201 Wheeler, Houston, Texas 77004, (713) 527-7190

WILCOX, Ms. Glenda - Parent, Wichita Child Day Care Association, Suite 804, Century Plaza, 111 West Douglas, Wichita, Kansas 67202, (316) 265-0871

WILLIAMS, Ms. Laverne - Program Director, Tri-City Head Start, Hartman Building, Box 378, Hughesville, Maryland 20637, (202) 843-6442

ZAMORA, Dr. Gloria - Director, Bilingual-Bicultural Curriculum Project, Intercultural Development Research Associates, 5835 Collaghan, Suite 3, San Antonio, Texas 78228, (512) 684-8180